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Nottingham City Council

Nottingham City Council
Health Scrutiny Committee

Date: Thursday, 15 October 2020

Time: 10.00 am (pre-meeting for all Committee members at 9:30am)

Place: To be held remotely via Zoom - meeting participants will be given access details.
Meeting will be livestreamed on the Council's YouTube Channel - https://www.youtube.com/user/NottCityCouncil

Councillors are requested to attend the above meeting to transact the following business

Director for Legal and Governance

Senior Governance Officer: Jane Garrard **Direct Dial:** 0115 876 4315

1	**Apologies for absence**	
2	**Declarations of interest**	
3	**Minutes** To confirm the minutes of the meeting held on 17 September 2020	3 - 8
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If you need any advice on declaring an interest in any item on the agenda, please contact the Governance Officer shown above, if possible before the day of the meeting

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Nottingham City Council

Health Scrutiny Committee

Minutes of the meeting held remotely via Zoom and livestreamed on the Council's YouTube Channel - https://www.youtube.com/user/NottCityCouncil on 17 September 2020 from 10.05 am - 11.25 am

Membership

Present	**Absent**
Councillor Georgia Power (Chair)	
Councillor Cate Woodward (Vice Chair)	
Councillor Samuel Gardiner	
Councillor Phil Jackson	
Councillor Maria Joannou	
Councillor Kirsty Jones	
Councillor Angela Kandola	
Councillor Dave Liversidge	
Councillor Lauren O`Grady	
Councillor Anne Peach	

Colleagues, partners and others in attendance:

Ajunta Biswas	-	Healthwatch Nottingham and Nottinghamshire
Lucy Dadge	-	Chief Commissioning Officer, Nottingham and Nottinghamshire Clinical Commissioning Group
Caroline Nolan	-	System Delivery Director – Urgent Care, Nottingham University Hospitals NHS Trust
Mark Simmonds	-	Consultant in Acute Critical Care Medicine, Nottingham University Hospitals NHS Trust
Jane Garrard	-	Senior Governance Officer

6 Apologies for absence

None

7 Declarations of interest

None

8 Minutes

The minutes of the meeting held on 16 July 2020 were approved as an accurate record and signed by the Chair.

9 Changes to NHS services in response to Covid-19

Lucy Dadge, Chief Commissioning Officer, gave a presentation updating the Committee on the current status of services that were changed in response to the Covid-19 pandemic. She highlighted the following information:

a) A number of services have been fully or partially restored to pre-Covid delivery models, some services have changed slightly and there are still some services that have yet to be restored. Details of this are set out in the report circulated with the agenda.

b) Moving into the recovery phase, work is taking place to identify how the health and social care system needs to look different going forward. In some cases there will be a desire to accelerate already planned change and other changes will be in response to emerging issues such as particular health inequality aspects.

c) There are two main areas – acute stroke services and the urgent care pathway – that changed in response to the Covid-19 pandemic based on transformation work that was already being considered prior to the pandemic. Work is taking place to review the benefits of these changes and therefore whether the changes should be retained. Proposals for permanent change will be subject to the usual requirements for engagement and consultation.

During subsequent discussion the following points were raised and responded to:

d) Throughout the Covid-19 outbreak, patients have still been able to have interventions with their GPs and GPs continued to refer patients for secondary care, including operations. However, due to safety considerations, the Trust has been unable to carry out some operations and waiting lists have increased. Waiting lists are reviewed by clinicians, but for a range of operations patients will experience delays.

e) Some health inequalities have been exacerbated by Covid-19 and, in particular the disproportionate impacts on Black, Asian and Minority Ethnic patients and staff is recognised. A lot of work is taking place to explore these issues.

f) Nottinghamshire Healthcare Trust responded quickly to the need to provide mental health services differently and put in place 24hour wrap around crisis care. It is recognised that there may be some demand for specialist mental health services to deal with Covid-related issues and the Trust is looking at how to respond to this. Overall there has been an increase in capacity for mental health service delivery within the Trust.

g) The recently revised national guidance on access by partners to maternity services will be implemented locally.

h) In the early stages of the pandemic there were pharmaceutical shortages but currently there are no significant issues in relation to this.

i) Detailed national guidance is being developed on the rehabilitation needs for patients post-Covid and this guidance will be responded to locally.

Mark Simmonds, Consultant in Acute Critical Care Medicine, updated the Committee on the reconfiguration of acute stroke services provided by Nottingham University Hospitals NHS Trust (NUH), noting that transformation work had been underway prior to the pandemic and was implemented in an accelerated way in response, and the outcomes are being reviewed to assess whether changes should be retained permanently. He highlighted the following information:

j) In response to the Covid-19 pandemic, there was an urgent need to make changes to ensure that patients with Covid-19 could be treated separately from patients without Covid-19 by creating additional admission assessment capacity on the City Hospital campus. The only suitable area was the Stroke Unit, which was located on the respiratory corridor.

k) Hyper acute stroke services were brought together on the Queens Medical Centre (QMC) site, with the Hyper Acute Stroke Unit and Acute Stroke Ward moved from the City Hospital campus.

l) Stoke rehabilitation services have remained on the City Hospital campus.

m) This reconfiguration of stroke services was already being considered prior to the Covid pandemic as there is analysis that it would be clinically beneficial for the treatment of stroke, it aligns to regional and national plans for stroke services and supports the longer term strategic direction for NUH as articulated through the Tomorrow's NUH programme. The move was accelerated to support the response to the Covid pandemic.

n) Treatment of strokes has changed considerably over recent years and since the previous configuration of services was established. It has been demonstrated that acute, rapid intervention improves outcomes and there have been a range of new interventions introduced many of which overlap with services provided on the QMC site. Another benefit of centralising acute stroke services on the QMC site is 24 hour a day, seven days a week access to the CT scanner in the Emergency Department.

o) Analysis so far shows that it has been a positive move. A full review will be carried out in November and if, following that review, it is proposed to make the changes permanent then those proposals will be brought to this Committee for consideration and there will be appropriate public and patient engagement and consultation.

Caroline Nolan, System Delivery Director – Urgent Care updated the Committee on plans in relation to the urgent care pathway which has also changed to support response to the Covid-19 pandemic and consideration is being given to retaining those changes permanently. She highlighted the following information:

p) There have been a number of key changes that were already being planned before the Covid-19 outbreak and brought forward as they were identified as being beneficial for managing services during the outbreak.

q) The Urgent Treatment Unit has been relocated from the QMC campus to Platform 1, Upper Parliament Street to support the response to the Covid-19

outbreak and enable more space to be available in the Emergency Department area to meet Covid requirements for social distancing.

r) The service continues to operate 24 hours a day, seven days a week and accepts patients from the Emergency Department. The number of patients seen has significantly reduced but this reflects a reduction in patients using face to face urgent care services. This reduction and the location has enabled NEMS to provide more telephone-triaging as well as providing face to face services if needed.

s) The new location fits with the improved navigation that should flow from the '111 First' pathway, with less need for primary care to be co-located with the Emergency Department.

t) Given the continued need for social distancing within the Emergency Department and its support for the wider direction of travel in urgent care services, it is intended to keep the service in its new location and monitor attendances across the pathway and amend the service offer as appropriate.

u) The new '111 First' initiative is a national change being introduced on 30 November, stating that NHS 111 or a GP practice is the first place that an individual should go when experiencing a health issue that is not immediately life threatening (rather than immediately going to a physical location). 111 will then book patients direct appointments with time slots at the appropriate service enabling demand for urgent care to be better managed.

v) It is envisaged that this will take advantage of the remote working technology that has been widely used during the Covid-19 outbreak and should help prevent hospital acquired infections because patients do not need to congregate together in the Emergency Department waiting to be seen.

w) Systems are being put in place to support a transfer of 20% of unheralded Emergency Department attendances (the national objective) to the 111 services, such as improving the Directory of Services and increasing the number of dispositions available on the Directory.

x) New access routes to emergency care assessment and hot clinics are being opened to reduce the need for people to unnecessarily walk through the Emergency Department.

y) Lots of communication work is taking place to support this change and it is hoped that having a timed appointment will be an incentive for individuals to engage with the new pathway.

z) This approach aligns with the Navigation and Access Model strand of the Urgent and Emergency Care Clinical Strategy which was developed pre-Covid. NHS 111 has a key role to play is supporting good navigation through the system and therefore this national initiative is welcomed locally.

aa) The benefits include that individuals should be seen by the appropriate service in a timely way with reduced waiting times; it should enable safer and more timely

care for those individuals who do need to attend the Emergency Department; the Emergency Department should be able to operate in a more effective way reducing risks to patients and staff; and the transfer of patient information will allow greater oversight of patient flows and an improved ability to match capacity with demand.

bb) A range of stakeholders have been spoken to about this new approach and this is informing implementation. There will be a specific focus on trying to reach those who are over-represented in Emergency Department attendances.

During subsequent discussion, it was confirmed that there will be clear pathways for mental health accessible by NHS 111.

The Committee requested that if commissioners decide to propose that changes in relation to the reconfiguration of acute stroke services are made permanent, those proposals along with plans for consultation and engagement are presented to the Committee for consideration.

10 Tomorrow's NUH (Nottingham University Hospitals)

Lucy Dadge, Chief Commissioning Officer, gave an early briefing about ‘Tomorrow’s NUH’ (Nottingham University Hospitals), highlighting the following information:

a) NUH is currently based on three main sites and although the Care Quality Commission has assessed the quality of care as good, the estate is not fit for the future and requires significant ongoing investment and reconfiguration. This is an exciting opportunity to address these issues for the benefit for the whole healthcare system.

b) Through the Hospital Infrastructure Programme, national funding has been identified for 40 new hospitals to be delivered in two waves. NUH has been identified as a potential Trust for this capital investment.

c) NUH will be developing a case for capital investment, but prior to that there is a need to demonstrate the case for change in terms of service improvement and outcomes. The Clinical Commissioning Group will be leading on this, informed by engagement with the Trust. This will include carrying out population health needs analysis, engaging with clinicians to explore innovate new ways to provide services and ensuring good links with the primary and community care sectors. The ambition is for the highest quality facilities to be available for hospital care, when it is needed.

d) Work is currently at an early stage. Engagement and consultation will be carried out at appropriate points in development of proposals. This will include engagement with the Nottingham and Nottinghamshire Health Scrutiny Committees. It is anticipated that the pre-consultation business case will be presented to the scrutiny committees in spring 2021, with wider consultation carried out in summer 2021. There will be engagement with the general population on the overall changes and consultation with patients, and other stakeholders, on specific clinical changes.

e) This represents not just an opportunity for health services but also has wider benefits for the economy, academic research etc.

During the subsequent discussion the following points were raised and responded to:

f) During the development, services will continue to be provided in a safe way that maximises patient experience.

g) The impact on the environment and environmental consideration should be taken into account in the development of proposals. Transport and access to care will be a factor and there will need to be a balance between access and carbon-reduction strategies.

h) The business case will determine the level of investment in new building. It isn't possible to pre-judge the outcome of that, but at this stage it seems unlikely that it will be an entirely new hospital site. A range of options will be looked at to try and achieve the best possible estate for the population.

i) The Naylor Review is about efficiency and a desire for a more efficient and effective system is driving this work.

j) Restrictions as a result of the Covid-19 pandemic could impact on the ability to carry out consultation in a way that everyone is able to engage with and is representative of the populations. It is hoped that it will be possible to carry out face to face consultation by summer 2021 but that it is currently unknown and these issues will need to be taken in account.

11 Work Programme

The Committee noted its current work programme for 2020/21, acknowledging the need to retain flexibility to deal with issues as they arise given the current circumstances.

12 Future meeting dates

The Committee agreed to meet on the following Thursdays at 10am:

- 15 October 2020
- 12 November 2020
- 17 December 2020
- 14 January 2021
- 11 February 2021
- 11 March 2021
- 15 April 2021

Health Scrutiny Committee
15 October 2020

Managing winter pressures

Report of the Head of Legal and Governance

1 Purpose

1.1 To review plans for managing winter pressures across health and adult social care services, particularly in the context of the current Covid-19 pandemic.

2 Action required

2.1 The Committee is asked to review plans for managing winter pressures across the health and social care system.

3 Background information

3.1 The Committee is aware of the considerable pressures faced by health and social care systems during the winter period and every year reviews winter pressures planning and, where appropriate, how particular pressures were responded to. Concerns have been raised nationally and locally that the current Covid-19 pandemic will make this a more challenging period than usual.

3.2 The Committee has invited representatives of Nottingham and Nottinghamshire Clinical Commissioning Group, Nottingham University Hospitals NHS Trust and the Council's Adult Social Care Team to discuss their plans for managing winter pressures during the 2020/21 winter period and how partners are working together on this across the health and social care system.

4 List of attached information

4.1 Briefing co-ordinated by Nottingham and Nottinghamshire Clinical Commissioning Group

Briefing on the Adult Social Care Winter Plan (to follow)

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6 Published documents referred to in compiling this report

6.1 None

7 Wards affected

7.1 All

8 Contact information

8.1 Jane Garrard, Senior Governance Officer
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0115 8764315

Managing winter pressures

Briefing

October 2020

At the Health Scrutiny Committee meeting on 15 October 2020 we will be presenting our plans to manage winter pressures for the Nottingham and Nottinghamshire Health and Care System. This briefing provides an overview of those plans.

The following sections provide a summary of the plans we will present to the committee for discussion.

Coordination of winter planning

Our Emergency Preparedness Resilience & Response arrangements provide system wide coordination of our management of winter pressures through:

- Local Resilience Forum
- Local Health resilience Partnership
- Organisational level planning.

These arrangements provide structured and coordinated oversight of pressures arising through the winter period and enable us to respond as a system.

Main areas of risk

As we move into winter 2020/21 there are a number of interrelated challenges that require a system response:

- Covid 19 "second spike"
- Winter pressures including Flu
- End of the EU Exit Transition Period (31/12/20)
- Restoration and Recovery
- Delivery of a large scale vaccination programme for Covid 19.

Focus of the 2020/21 winter plan

The 2020/21 system winter plan has a wide ranging focus and includes the following key areas.

Urgent care coordination

Arrangements to manage the impact of winter pressures on urgent care services are overseen by the A&E Delivery Board. They include daily system monitoring and escalation and daily monitoring of delays in discharges. These arrangements enable the system to react to and reduce the impact of winter pressures on services.

Key drivers for pressure on our acute hospitals relate to:

- Higher acuity of patients
- High prevalence of influenza
- Increase in admissions in respiratory and HCOP
- Increase in beds closed due to infection (norovirus, D&V, CRE etc)
- Increased bed occupancy
- A&E attendance, exacerbated by Covid-19 social distancing requirements
- Staffing pressures exacerbated by Covid-19.

These are likely to be exacerbated this winter by the impact of Covid-19.

Flu and Covid vaccination programme

We are targeting areas we know have low update for vaccinations. Data is collected at practice level to inform targeted interventions.

The national Covid vaccination programme is under development for local implementation from November 2020.

Focus in primary care

General Practice continues to offer telephone triage; phone, video and online consultations and face-to-face consultations. Increasingly we are making use of digitation through online booking and 111.

Planning for Covid-19 post wave 1

Plans for managing a second wave of Covid-19 continue to be coordinated within individual NHS organisations, between health organisations and at a multi-agency level.

The Covid-19 Pandemic is classified as a National Level 3 incident (an incident that requires the response of a number of health organisations across geographical areas within a NHS England region).

Health Scrutiny Committee
15 October 2020

NHS Rehabilitation Centre

Report of the Head of Legal and Governance

1 Purpose

1.1 To consider proposals for development of an NHS Rehabilitation Centre.

2 Action required

2.1 The Committee is asked to:

a) consider the findings of consultation carried out in relation to the proposed NHS Rehabilitation Centre as part of the Committee's role in relation to substantial variations or developments of service; and

b) request that details of the proposed way forward are presented to the Committee's meeting on 12 November so that the Committee can consider:
   i. whether, in developing the proposals for service changes, the CCG has taken into account the public interest through appropriate patient and public involvement and consultation; and
   ii. whether the proposal for change is in the interests of the local health service.

3 Background information

3.1 The Committee has previously heard from the Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) about proposals for development of an NHS Rehabilitation Centre on the Stanford Hall Estate, where the Ministry of Defence Medical Rehabilitation Centre is sited; and plans for public consultation on the proposals, including commissioning Healthwatch Nottingham and Nottinghamshire to deliver targeted engagement with vulnerable and seldom heard groups. The consultation, and decision making timelines were subsequently delayed due to the Covid-19 pandemic.

3.2 The public consultation has now closed and the CCG is in the process of considering the findings of the consultation and how to proceed. A briefing from the CCG accompanied by the Consultation Findings Report and a report by Healthwatch Nottingham and Nottinghamshire is attached.

3.3 Based on the information provided to it, the proposals are considered to be a substantial variation of services and therefore the Committee has a responsibility to consider:

- whether, as a statutory body, it has been properly consulted within the consultation process;
- whether, in developing the proposals for service changes, the commissioners have taken into account the public interest through appropriate patient and public involvement and consultation; and
- whether the proposal for change is in the interests of the local health service.

3.4 In order to fulfil this role, the Committee is asked to review the consultation carried out and the findings of that consultation and then to request that details of the proposed changes are presented to its next meeting in November so that the Committee can consider:
   a) whether, in developing the proposals for service changes, the CCG has taken into account the public interest through appropriate patient and public involvement and consultation; and
   b) whether the proposal for change is in the interests of the local health service.

4 List of attached information

4.1 Briefing from Nottingham and Nottinghamshire Clinical Commissioning Group

Public Consultation on the Development of an NHS Rehabilitation Centre Findings Report October 2020

Healthwatch Nottingham and Nottinghamshire NHS Rehabilitation Centre Report September 2020

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6 Published documents referred to in compiling this report

6.1 Reports to, and minutes of meetings of the Health Scrutiny Committee held on 12 September 2019 and 16 January 2020.

7 Wards affected

7.1 All

8 Contact information

8.1 Jane Garrard, Senior Governance Officer
jane.garrard@nottinghamcity.gov.uk
0115 8764315

NHS Rehabilitation Centre – Update to the Nottingham City Health Scrutiny Committee

Briefing

October 2020

On 18 September 2020 our public consultation on proposals to develop an NHS Rehabilitation Centre closed. We are currently in the process of considering the findings of that consultation and will be developing a Decision Making Business Case (DMBC) that will be presented to our Governing Body on 2 December 2020. The DMBC will detail how we have incorporated the findings of the consultation into our plans and make recommendations to the Governing Body on how best to proceed.

To inform the development of the DMBC a Findings Consideration Panel (FCP) has been established and will meet on 9 October 2020 and 23 October 2020. The panel will review the consultation findings and highlight areas that should be considered when developing the DMBC. The panel is comprised of CCG Non-Executive Directors and Officers; Healthwatch Nottingham and Nottinghamshire and patient representatives.

We have enclosed two draft reports of consultation findings. These are:

- The main consultation findings report
- Report by Healthwatch Nottingham and Nottinghamshire.

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JHARVEY

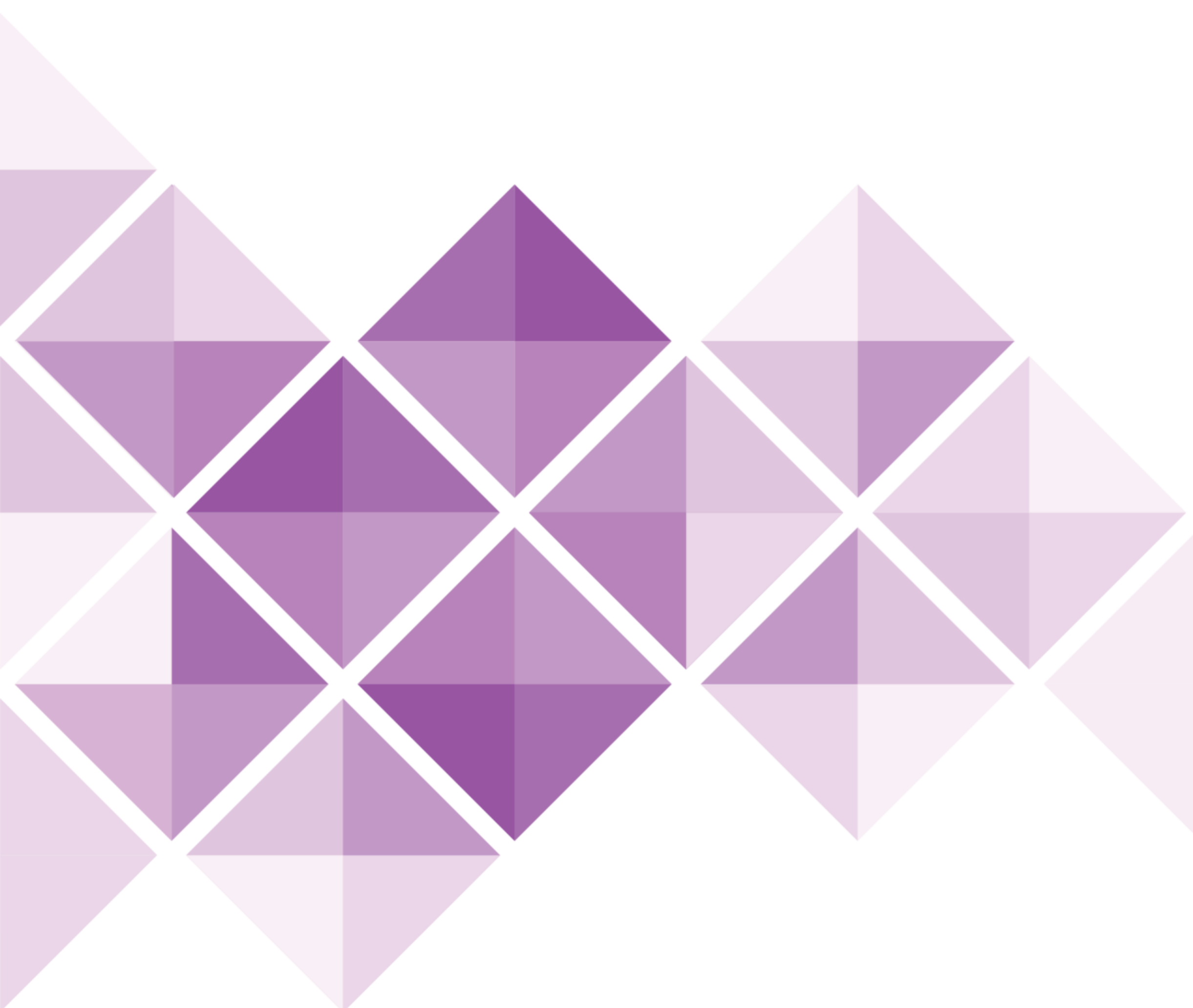
NHS
North of England
Commissioning Support Unit

Public Consultation on the Development of an NHS Rehabilitation Centre

Findings Report

October 2020

Version 1.0



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Executive Summary

Introduction

On the 27th July 2020, NHS Nottingham and Nottinghamshire Clinical Commissioning Group launched a public consultation on the opportunity to open an NHS Rehabilitation Centre in the East Midlands.

Specialist rehabilitation services are currently delivered from hospitals across the region, with neurological rehabilitation provided at Linden Lodge at Nottingham City Hospital. According to estimates by the British Society of Rehabilitation Medicine there is a significant shortfall of rehabilitation beds across the region.

Central Government has ring-fenced £70 million to build a Rehabilitation Centre for NHS inpatients on the same site as the Defence Medical Rehabilitation Centre on the Stanford Hall Rehabilitation Estate, near Loughborough. This would result in a net increase of 40 rehabilitation beds across the East Midlands and provide NHS patients with access to a skilled team of experts working in a purpose-built facility and use of the latest technology and equipment.

The development would mean transferring 21 of the 24 specialist rehabilitation beds in Linden Lodge to the new purpose-built facility. The three remaining specialist rehabilitation beds would be retained at Nottingham City Hospital in a dedicated rehabilitation unit. Patients would continue to access outpatient appointments and rehabilitation services in local hospitals throughout the East Midlands.

The eight-week consultation ran from the 27th July to 18th September 2020 and consisted of engagement events, focus groups and a survey. Direct submissions from individuals and stakeholders were also encouraged. In total, 876 people or organisations participated during the consultation period.

J. Harvey Research Ltd, an independent organisation from outside the region, was commissioned by the North of England Commissioning Support Unit to report the findings of the consultation.

Key findings

Results from the survey show that:

- 77% strongly support the proposal to create a NHS Rehabilitation Centre at the Stanford Hall Estate. A further 9% slightly support it.
- 52% strongly support the proposal to transfer the service currently provided at Linden Lodge to the NHS Rehabilitation Centre. A further 15% slightly support this.
- 65% feel it is appropriate for NHS patients to be treated on the same site as military personnel. A further 22% perceive that it is to some extent.

- 33% feel that it would be very easy for them to access the NHS Rehabilitation Centre at the Stanford Hall Estate, whilst 19% perceive it will be easy. In contrast, 24% stated it would be difficult or very difficult and 24% neither easy nor difficult.

- 60% feel that the provision of three rooms for families to stay, free parking and super-fast broadband would help to reduce the impact of increased travel time that some might face. A further 26% perceive that it would to some extent.
- 73% feel that the care that patients would receive at the NHS Rehabilitation Centre will be excellent. A further 17% perceive it will be very good.

- 66% feel the range of health and social care professionals that patients would have access to is excellent. A further 21% perceive it is very good.

- 72% feel confident that patients' mental health is being taken into account. In contrast, 22% feel that although patients' mental health is being taken into account more could be done and 7% that more needs to be done.

Benefits of the proposal

Numerous benefits of the development of a NHS Rehabilitation Centre were identified by consultees. These include:

- Providing NHS patients with access to a purpose-built rehabilitation facility with all expertise under one roof, in addition to the state-of-the-art facilities at the Defence Medical Rehabilitation Centre.

- Increasing access to specialist inpatient rehabilitation, addressing the unmet need that exists and reducing the demand on acute NHS services.

- Improving patient outcomes.

- Collaboration with the Defence Medical Rehabilitation Centre in terms of sharing of resources and best practice.

- Transforming how rehabilitation is delivered across the system, setting a 'blue print' for other parts of the country.

- Opportunity for local public sector collaboration in the areas of education and research.

Furthermore, most survey respondents perceive the main benefit of the NHS Rehabilitation Centre's location at the Stanford Hall Estate is the rural, tranquil setting which provides access to fresh air and open space - a stark contrast from that of a busy hospital environment. A smaller proportion feel the Stanford Hall Estate is centrally located in the East Midlands region, as well as in the UK, and accessible by car and

public transport (42% & 14% of survey respondents who responded to this question cited these benefits, respectively).

Concerns about the proposal

In contrast, strong concerns were raised about the proposal, particularly with regard to the NHS Rehabilitation Centre's location at the Stanford Hall Estate. A number of extensive submissions were received by stakeholders, particularly professional bodies/organisations, which challenged the proposal on a number of grounds and perceived that the proposal lacked significant detail.

Specific concerns/objections to the proposal include:

- The poor accessibility of the Stanford Hall Estate which will create difficulty for visitors and staff to access, in terms of increased travel time and cost. This was considered a particular issue for those reliant on public transport as well as older and/or vulnerable individuals.

- The knock-on effect on patients' wellbeing if they are unable to see their friends and family on a frequent basis, as well as the difficulty for these individuals to be involved in their relatives' rehabilitation. The vital role that family and friends play in the process was repeatedly emphasised.

- Patients who require inpatient rehabilitation need access to a range of acute medical and surgical services due to their medical instability and complex needs. For this reason, concern was raised about the medical safety of patients if the current caseload at Linden Lodge were to be managed in this new service. Additionally, there was concern about the rehabilitation options available to those who are ineligible to receive their care at the NHS Rehabilitation Centre and/or are unable to engage in intensive rehabilitation.

- It was felt that patients will have reduced continuity of care beyond inpatient stay due to the distance of the Stanford Hall Estate from acute NHS services. It was noted that transferring patients to and from these services will eat into their 'rehabilitation time' and deplete their energy to engage, whilst also requiring the availability of staff to escort.

- The distance from, and inability for patients to practice 'real world' situations e.g. crossing busy roads, getting on and off public transport, going to a shop, was perceived to limit the ability and relevance of rehabilitation. For this reason, many consultees highlighted the importance of receiving rehabilitation care within local communities.

- The closure of Linden Lodge, a facility considered to be more easily accessible, providing a high standard of care and benefitting from the proximity to acute NHS services and provide local inpatient care.

- The impact the location on the transition from inpatient to community care, as well as concern as to whether the 'step-down' care available within local communities is able to maintain, and build upon, progress achieved at the NHS

Rehabilitation Centre. This is a particular concern in Lincolnshire, which is felt to not have the aftercare support in place to continue the care required post discharge.

- Potential conflict between the Defence Medical Rehabilitation Centre and the NHS Rehabilitation Centre in terms of the shared use of facilities as well as the issues of dealing with two very different population cohorts and the potential for inequalities in treatment to be highlighted.

- Practicality of having a three-bedded rehabilitation unit at Nottingham City Hospital.

- Difficulties in the recruitment of specialist staff as well as the impact on staff at Linden Lodge.

- Suitability of the site for the placement of trainees in rehabilitation medicine.

- The impact on the surrounding area at Stanford due to the increased volume of traffic, which many already perceive to be a problem.

- Other including; financial modelling and sustainability, safety of visitors travelling and accessing the site, decisions already being made, privatisation, commissioning and equity in access for all areas.

Considerations

In light of these issues and the strong concern that some stakeholders have about the feasibility of the proposal as it stands, a number of significant modifications to the proposal were put forth by consultees:

- Investing in the existing building/-facilities at Linden Lodge

- The reorganisation of rehabilitation provision within existing buildings and organisations.

- Developing the NHS Rehabilitation Centre as an additional facility to Linden Lodge – helping to increase inpatient rehabilitation capacity whilst catering for patients with different rehabilitation needs.

- Developing the NHS Rehabilitation Centre as a tertiary service/national centre for specific cohorts of medically stable patients, who are well enough to engage in a benefit from a very intensive residential rehabilitation programme.

- Incorporation of a dynamic outpatient service.

- Opportunities for day-case/weekly boarding.

Additional, less significant, suggestions were made in relation to increasing accessibility to the Estate through methods such as improving public transport links and/or the provision of shuttle bus services from local hospitals, increasing the number of family rooms, and enhancing the mental health support available to patients through the presence of more mental health professionals and the provision of a wider range of therapy options.

Next steps

This report will be provided to the NHS organisations leading the consultation. A Findings Consideration Panel will consider the report and make recommendations on how best to reflect the consultation findings in their final proposals.

A Decision Making Business Case will then be developed and considered by the CCGs' Governing Body, before making a final decision on the development of the NHS Rehabilitation Centre. This is expected to take place by the end of 2020.

1 Introduction

On the 27th July 2020, NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) launched an eight-week consultation on the opportunity to open an NHS Rehabilitation Centre (NHSRC) in the East Midlands.

Specialist rehabilitation services are currently delivered from hospitals across the region, with neurological rehabilitation provided at Linden Lodge at the City Hospital in Nottingham. Patients who require specialist rehabilitation generally have complex disabilities, often with a range of medical, physical, sensory, mental, communicative, behavioural and social problems. They may have experienced:

- Major trauma following, for example, a road traffic collision or an accident at work
- Neurological problems such as an injury to the brain
- Complex musculoskeletal injury with damage to the bones, joints and muscles
- Traumatic amputation
- Incomplete spinal cord injury resulting in paralysis
- Post Covid-19 (Coronavirus) conditions.

The British Society of Rehabilitation Medicine (BSRM) recommends that the ideal level of rehabilitation beds should be 45 to 65 beds per million people. There is currently a significant shortfall of these beds in the East Midlands.

Central Government has provided £70 million to build a Rehabilitation Centre for NHS inpatients on the same site as the Defence Medical Rehabilitation Centre (DMRC) on the Stanford Hall Rehabilitation Estate (SHRE), near Loughborough. The owner of the SHRE is prepared to provide the land needed for the NHS facility at no cost.

The new centre would result in a net increase of 40 rehabilitation beds across the East Midlands and provide NHS patients with access to a skilled team of experts working in a purpose-built facility with access to the latest technology and equipment.

The development of the centre would mean transferring 21 of the 24 specialist rehabilitation beds in Linden Lodge to the new purpose-built facility. The three remaining specialist rehabilitation beds would be retained at Nottingham City Hospital in a dedicated rehabilitation unit.

Patients would continue to access outpatient appointments and rehabilitation services in local hospitals throughout the East Midlands.

It is anticipated that the NHSRC would:

- Create a high-quality centre of rehabilitation excellence
- Contribute to a deficit in rehabilitation capacity
- Improve access to services
- Improve outcomes and the patient experience through a new clinical model
- Enable NHS Nottingham and Nottinghamshire CCG to respond to changes in future service needs and models
- Reduce pressures on the acute bed base.

The proposal being consulted upon, builds upon the findings from two pieces of engagement conducted in July and October 2019 which aimed to understand initial perceptions about the development of the NHSRC among patients and staff. While those engaged with were mostly positive about the proposal, concerns were raised about the location and accessibility of the facility, the potential for patients to feel lonely and isolated, as well as the impact on local services. The CCG has carefully considered how best to respond to these concerns within the current proposal.

The public consultation ran from the 27th July to 18th September 2020 and consisted of online engagement events, focus groups and a survey. All activity was required to take place online due to Covid-19 social distancing measures introduced earlier in the year. Individuals with direct or indirect experience of rehabilitation – either as a patient, through family members or friends as well as staff, carers and other stakeholders, were invited to give their views. This included those living in Nottinghamshire and neighbouring areas such as Leicestershire, Derbyshire and Lincolnshire, due to their proximity to existing specialist rehabilitation services.

J. Harvey Research Ltd, an independent organisation from outside the region, was commissioned by North of England Commissioning Support Unit to report the findings of the consultation.

The report will be provided to the NHS organisations leading the consultation. A Findings Consideration Panel will consider the report and make recommendations on how best to reflect the consultation findings in their final proposals. A Decision Making Business Case will then be developed and considered by the CCGs' Governing Body, before making a final decision on the development of the centre. This is expected to take place by the end of 2020.

2 Methodology

The North of England Commissioning Support Unit (NECSU) supported NHS Nottingham and Nottinghamshire CCG with their communications and engagement.

The objectives of the activity were:

- To ensure the maximum numbers of people were made aware of the consultation. This included those living in Nottingham and Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire.
- To encourage as many individuals as possible to take part in the consultation.
- To continue to meet NHS legal duties for engagement, equality and best practice in engagement and communications.

Due to Covid-19 social distancing measures all engagement activity was online and included engagement events, focus groups and a survey.

2.1 Communications activity

An initial briefing was cascaded to a wide range of stakeholders inviting all their communication staff to an online meeting about the consultation and asking for their support in cascading information to their networks. Follow up emails were sent with details of the engagement events and focus groups, as well as reminders about the importance of their input.

The stakeholder list included:

- Local CCGs - NHS Nottingham and Nottinghamshire CCG, NHS Derby and Derbyshire CCG, NHS Leicester City CCG and NHS Lincolnshire CCG
- Local Councils - Nottinghamshire County Council, Nottingham City Council, Leicester City Council, Derby City Council, Lincolnshire County Council, Derbyshire County Council, Leicestershire County Council, Lincoln City Council, Mansfield District Council, Newark & Sherwood District Council and Rushcliffe Borough Council
- Regional MPs
- Local NHS Trusts - Nottingham University Hospital, Nottinghamshire Healthcare, Sherwood Forest Hospitals, Royal Derby Hospital, Chesterfield Royal Hospital, East Midlands Ambulance Service, United Lincolnshire Hospitals, University Hospitals of Leicester and University Hospitals of Derby and Burton
- Local Universities - University of Nottingham, Loughborough University, University of Leicester, University of Derby and University of Lincoln

- Healthwatch – Nottingham and Nottinghamshire, Leicester and Leicestershire, Derbyshire and Lincolnshire

- Health Education England East Midlands and NHS England

- Other organisations and professional associations/bodies including but not limited to: CityCare, Optum, British Dietetic Association, Royal College of Occupational Therapists, Chartered Society of Physiotherapy, Highground UK, College of Podiatry and Mind UK.

An initial press release was sent to local media outlets at the start of the consultation, with a second on the 9th September reminding people to take part in the consultation. The table shows the media coverage achieved, along with the sentiment of each.

***Table**: Media coverage*

Type	Date	Organisation	Sentiment
Article	13th July	Nottingham Post /Nottinghamshire Live	Negative
	14th July	Leicester Mercury/Leicestershire Live	Positive
	17th July	Leicester Mercury	Positive
	27th July	National Health Executive (Web)	Neutral
	27th July	Nottingham Post/Nottinghamshire Live	Neutral
	29th July	Loughborough Echo	Positive
	1st August	Nottingham Evening Post	Neutral
	5th August	Loughborough Echo	Positive
	15th September	Leicester Mercury	Positive
Online	14th July	National Centre for Sports and Exercise Medicine	Positive
	14th July	AgenParl	Positive
	14th July	Leicestershire Live	Positive
	27th July	National Health Executive	Positive
	27th July	Nottinghamshire Live	Neutral

	31st July	Nottinghamshire Live	Neutral
	26th August	Chartered Society of Physiotherapy	Positive
	28th August	AT Today – Assistive Technology	Positive
Broadcast	13th July	BBC East Midlands Evening News	Positive
	14th July (x2)	BBC Radio Leicester	Unknown
	27th July (x2)	BBC Radio Nottingham (Drive-time)	Positive

Throughout the consultation period, NHS Nottingham and Nottinghamshire CCG posted on Facebook, as well as using paid for advertisements to target specific demographic profiles.

***Figure**: Screenshots - media coverage / Facebook posts*

nhe
NATIONAL HEALTH EXECUTIVE
home news blog comment interviews health service focus magazine editorial b

care pathways

Print
Email
Share
Comment

related

Sir James Bevan: Investing in nature could save NHS billions annually
NHS to open new Lighthouse Lab to further boost lab capacity
IMechE: Cutting-edge healthcare will require more engineers
What does hybrid cloud offer healthcare?
New service established to provide personal specialised stroke care
'Life-changing' plans to tackle £10bn a year condition come into effect
Coronavirus vaccine trials reach over 100,000 registered volunteers

27.07.20

Consultation launched over £70m Nottinghamshire NHS rehabilitation centre

Proposals to create a £70m NHS Rehabilitation Centre in Nottinghamshire, which could see services move from Nottingham city centre to a new specialist site near Loughborough, are set to undergo a public consultation period.

As part of the consultation process, patients, families and carers are being invited to give their views on transferring existing rehabilitation services from Nottingham City Hospital's Linden Lodge facility to a new centre at Stanford Hall Rehabilitation Estate.

The consultation comes after a health campaign group lodged its opposition to any

Nottingham University Hospitals NHS Trust
August 5

The consultation us underway on proposals to build a brand new centre of excellence for rehabilitation near Loughborough. Get involved and share your views
https://nottsccg.nhs.uk/rehab-centre-consultation/
#NHSRehabCentre

NHS Nottingham and Nottinghamshire CCG
August 3

Share your views on proposals to develop an NHS Rehabilitation Centre of excellence to benefit people across the East Midlands. Complete an online survey today.
#NHSRehabCentre
http://ow.ly/FNGQ50AOUCI

To increase participation from hard-to-reach groups, a number of organisations were contacted specifically by the CCG, providing their members/service users with the opportunity to discuss the proposal and respond to the survey in a one-to-one, telephone feedback session with a representative from Healthwatch Nottingham and Nottinghamshire. The organisations contacted included Nottinghamshire Carers Hubs, MH:2K – an organisation working with young people and Nottingham's Engagement Team for Children and Young People.

The following table documents the number of visits to the NHSRC's web page and document downloads, as well as ausmmary of the social media activity.

***Table**: Website and social media activity*

Website	Web page visits	4,747
	Web document downloads	1,014
Social media	Animation link clicks	2,814
	Animation reach (unique people seeing)	95,327
	Animation impressions (total displays)	247,646
	Social media engagement	• 170 reactions • 128 comments • 119 shares

2.2 Engagement activity

2.2.1 Engagement events

Three online engagement events were held during the consultation period. It was originally planned that these would be face-to-face, however due to Covid-19 restrictions these were all conducted online via Microsoft Teams.

Prior to the event, attendees were given the opportunity to submit any questions they had. This was in case individuals wanted to do this anonymously or were unable to use the chat function during the event.

At the start of each event, attendees were given an overview of the consultation by;

- Amanda Sullivan; Accountable Officer for Nottingham and Nottinghamshire CCG
- Dr James Hopkinson; Clinical Chair of Nottingham and Nottinghamshire CCG.

Attendees were then given the opportunity to ask any questions they had to the clinical leads or provide any comments they had about the consultation using the chat function.

A number of additional speakers were on hand to answer questions, this included:

- Miriam Duffy; NHSRC Programme Director at Nottingham University Hospital NHS Trust

- Sandeep Walsh; Rehabilitation Case Manager at East Midlands Major Trauma Centre; Nottingham University Hospital NHS Trust

- Hazel Buchanan; Associate Director of Strategic Programmes at NHS Nottingham and Nottinghamshire CCG

- Daren Forward; Consultant Orthopaedic Surgeon and Major Trauma Consultant at Nottingham University Hospital NHS Trust

- Adam Brooks; Major Trauma Consultant and Clinical Director at East Midlands Major Trauma Centre; Nottingham University Hospital NHS Trust

- Allan Cole; Consultant Anaesthetist at University Hospitals of Leicester NHS Trust, and recent recipient of complex trauma care.

Note: Not all these individuals were able to attend all of the events.

In total, 37 individuals attended the events, the breakdown of which is shown in the table below.

***Table**: Engagement events*

Date	Time	No. of attendees
Tuesday 4th August 2020	3-4pm	11
Thursday 10th August 2020	2.30-3.30pm	13
Wednesday 19th August 2020	6-7pm	13

2.2.2 Consultation survey

Members of the public, patients, staff, family members and other stakeholders were invited to complete an online survey developed to gather opinion upon the proposal.

In addition, paper and easy-to-read versions were available on request.

In total, 763 individuals responded to the survey.

2.2.3 Focus groups

Individuals who had a specific interest or experience of rehabilitation services were given the opportunity to join two online focus groups. For individuals, who expressed an interest but were unable to attend or felt uncomfortable using this technology, one-to-one telephone interviews were offered.

A discussion guide was used to create consistency between the groups / interviews and ensure that key questions were addressed. With permission of the participants, the

groups were audio recorded and an anonymised transcript produced for analysis purposes.

In total, 10 individuals participated in the focus groups / interviews, the breakdown of which is shown in the table below.

***Table**: Focus group / interviews*

Date	Time	No. of attendees
Monday 24th August 2020	2-3pm	4
Tuesday 1st September 2020	6-7pm	4
One-to-one telephone interviews	-	2

2.2.4 Stakeholder and other submissions

To ensure as fair an opportunity as possible was given for all to provide a contribution to the consultation, direct communications were encouraged and included in the process.

In total, 66 submissions to the consultation were received from members of the public through social media activity and stakeholders.

2.3 Total sample

In total, 876 people or organisations participated during the consultation period.

2.4 Analysis and reporting

J. Harvey Research Ltd was commissioned to provide an independent analysis of the findings of the consultation. The specific methods applied to analyse the findings were:

- Qualitative analysis: the findings from the engagement events and focus groups are constructed on an approach where the data from the session notes is analysed and responses grouped into themes that most closely represent the views expressed. Qualitative data does not allow for commentary on the specific number of times comments are made within these themes.

- Quantitative analysis: the survey was structured to include both closed and free text (open) questions giving respondents the opportunity to comment on the proposal in more detail. All free text responses were assigned a code, and codes grouped into categories to allow a quantitative representation of the feedback. For all questions, responses have been presented as a proportion of the number of individuals who responded to each question.

It is important to note, that respondents to the survey are self-selecting, representing the views of those who wanted to give their views. This is very important opinion but cannot be treated as statistically reliable.

This report presents the result of that independent analysis and is intended to inform decision makers of the views of consultees and to provide them with a summary of any additional information which they wish them to take into conscientious consideration.

3 Feedback from the engagement events

Three online engagement events were held during the consultation period, with a total of 37 individuals. This consisted of members of the public, past service users, NHS staff, health professionals as well as other stakeholders.

Attendees were given an overview of the consultation, followed by the opportunity to ask any questions they had to the clinical leads or provide their comments about the proposal. In total, 42 questions were asked and three comments provided.

The anonymised transcripts from the engagement events are available in the Appendix - these include responses from the clinical leads to the questions asked. The questions asked and comments provided have been summarised under the headings below to provide an overview of the themes of discussion.

3.1 Discussion themes

3.1.1 Planning and delivery of the NHSRC

- Managing organisation(s)
- Level of rehabilitative care
- Benefits, compared with current specialist inpatient provision
- Facilities/equipment available through the DMRC as well as availability/access of these to NHS patients
- Building layout/lift access
- Access for privately-funded patients
- Opportunities for day care
- Timescale for developing the National Centre for training and education
- Comparisons and learnings from equivalents in other countries.

3.1.2 Care and treatment

- Availability of medical cover
- Anticipated lengths of stay

- Continuity of care - neurological journey for complex patients
- Access to medical specialties i.e. dialysis facilities for renal patients.

"Currently there is neurophysiotherapy support from Linden Lodge on the acute neuro wards and reablement/outpatient ongoing support which is planned seamlessly on site."

3.1.3 Criteria for admission

- Eligibility criteria
- Access to the NHSRC for patients who are currently eligible for rehabilitative care at Linden Lodge
- Availability of neurobehavioural/neuropsychiatric beds at the NHSRC.

"*I have multiple sclerosis, I have many concerns about losing this facility, at the moment there are 24 neurorehabilitation beds, I am concerned that because we cannot be 'cured' we will be put at the back of the line for beds."*

3.1.4 Capacity and demand

- Access to/number of beds available for Nottingham/Nottinghamshire patients.

3.1.5 Geographical catchment

- Access to, and impact for Lincolnshire patients requiring inpatient rehabilitation
- Access for Northamptonshire patients.

"There are very little current services for inpatient brain injury rehabilitation in Lincolnshire now. Many patients have to go out of county for rehabilitation anyway."

3.1.6 Workforce

- Recruiting specialist staff given the ongoing workforce issues
- Recruitment criteria/staff banding (i.e. opportunities for Band 5 therapists/students)
- Access to on-site staff accommodation and travel-to-work schemes
- Attitudes/feelings of staff at Linden Lodge
- Opportunities available to staff who do not want to relocate/rotate.

3.1.7 Discharge and outpatient care

- Movement of patients from the NHSRC to step-down provisions and/or multi-disciplinary teams (MDTs) for further rehabilitation
- Role of the NHSRC in providing rehabilitation within the community
- Opportunities to link with private organisations to support the discharge process
- Location of outpatient care for Nottingham/Nottinghamshire and Lincolnshire patients
- Continuity of care for Lincolnshire patients
- Capacity of community rehabilitation services in the counties able to refer patients to the NHSRC.

3.1.8 Financial

- Length of the lease on the SHRE site
- Running costs (i.e. where will the money come from to run the service?)
- Financial impact on other NHS services due to the acute beds made available being filled by other patients
- Financial implications for the care and treatment of veterans.

"Great for us patients but are there knock-on effects to affordability for other NHS services."

3.1.9 Location

- Potential impact of family members/other visitors being able to see their loved ones less frequently.

3.1.10 Other

- Timeline for the decision-making process
- Use of the current inpatient building at Linden Lodge.

4 Feedback from the consultation survey

4.1 Participant demographics

A total of 763 individuals responded to the survey; 66% of which were from Nottingham City or Nottinghamshire. Furthermore, 11% were from Leicester/Leicestershire, 10% from Derby/Derbyshire and 4% Lincoln/Lincolnshire. The remaining individuals stated that they were from another part of the UK (8%) or lived within the East Midlands (1%).

***Table**: Location of respondents*

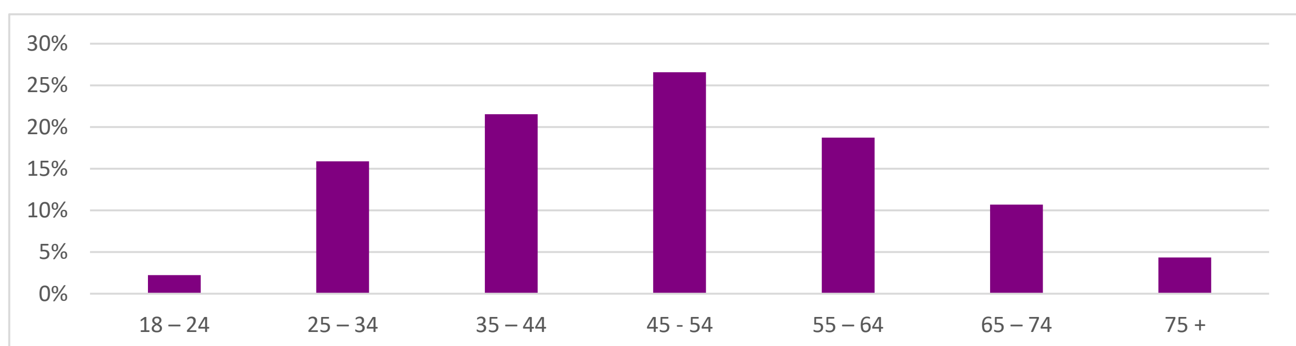
	No.	%
Rushcliffe (Nottinghamshire)	181	25%
Nottingham City	114	16%
Leicester/Leicestershire	79	11%
Broxtowe (Nottinghamshire)	74	10%
Derby / Derbyshire	69	10%
Other part of the UK	60	8%
Gedling (Nottinghamshire)	47	7%
Newark and Sherwood (Nottinghamshire)	30	4%
Lincoln/Lincolnshire	27	4%
Ashfield (Nottinghamshire)	16	2%
Mansfield (Nottinghamshire)	10	1%
East Midlands – not specified	7	1%
Total	**714**	**100%**

The demographics of respondents are summarised below, with a full breakdown available in the Appendix.

- The majority were female (78%), whilst 21% were male and <1% other. All indicated that their gender matched their sex registered at birth.

- The age profile of respondents was normally distributed, with most aged between 45 to 54 years (27%). Furthermore, similar proportions were aged 35-44 years (22%) and 55 to 64 years (19%). Slightly smaller proportions were aged 25 to 34 years (16%), 65 to 74 years (11%), 75 or older (4%) and 18 to 24 years (2%).

***Figure**: Age distribution of respondents*



- The vast majority was White (94%), smaller proportions were White – Irish (2%), Asian/British Asian - Indian (1%) and Asian/British Asian – Pakistani (1%).
- Just 2% were currently pregnant or had been in the last year.
- Most were married (64%), whilst 14% were cohabiting and 11% single. Smaller proportions were divorced/civil partnership dissolved (3%), separated (1%) or in a civil partnership (1%).
- The majority had no known impairment, long-term illness or health condition (69%). Of those that did, the most common were; a long-term illness or health condition such as HIV, diabetes or epilepsy (8%), a physical impairment (8%), a mental health difficulty (5%) or an impairment, health condition or learning difference not listed in the survey (5%).
- Less than a fifth were an unpaid carer of a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or addiction (15%).
- The majority were heterosexual or straight (93%), whilst 3% identified themselves as asexual, 2% bisexual and 2% gay woman/lesbian or gay man.
- Most did not have a religion (47%) or stated being a Christian (40%).

Individuals were asked to indicate how they were responding to the survey, to which the majority indicated they were answering as a member of the public (69%). Smaller proportions responded as a current or former patient of rehabilitation services (10%), a carer/friend/family member of an individual who is accessing/has accessed a rehabilitation service (9%), a member of NHS staff (8%) or as a charity/voluntary organisation (1%). The latter included organisations such as POW Nottingham, Lincolnshire Neurological Alliance, Nottingham Multiple Sclerosis Therapy Centre, The Disabilities Trust, The Brain Injury Rehabilitation Trust and the Armed Forces Para-Snowsport Team.

Furthermore, 3% selected 'other'; this included health professionals such as a physiotherapist or dietician, organisations such as University of Nottingham, Neuro Rehab Kent, Physio Where You Are Ltd, Fresh Physio Ltd, Great Northern Physiotherapy Ltd, Rempstone Parish Council, Vanclaron CIC, Agile Nottingham and forums such as Health Scrutiny Committee for Lincolnshire and United Kingdom Acquired Brain Injury Forum.

***Table**: How individuals responded to the survey*

	No.	%
A member of the public	217	69%
A current or former patient of rehabilitation services	73	10%
A carer/friend/family member of an individual who is accessing / has accessed a rehabilitation service	71	9%
Member of NHS staff	57	8%
Other	25	3%

Charity / voluntary organisation	8	1%
Total	**751**	**100%**

4.2 Survey responses

4.2.1 Support for the proposal

The majority strongly support the proposal to create a NHSRC at the Stanford Hall Estate (77%), with a further 9% slightly supporting it. In contrast, 10% either strongly or slightly oppose, whilst 4% neither support nor oppose it.

***Figure**: To what extent do you support or oppose the proposal to create a NHSRC at the SHRE near Loughborough?*

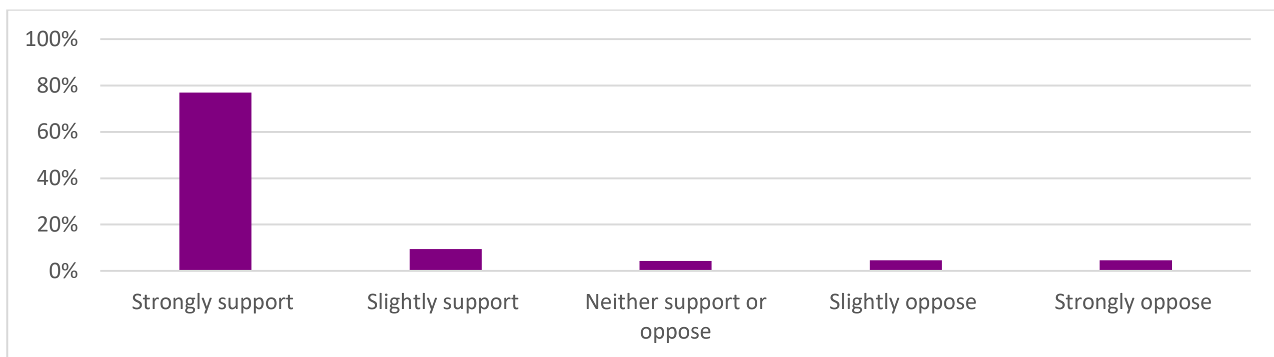


***Table**: To what extent do you support or oppose the proposal to create a NHSRC at the SHRE near Loughborough?*

	No.	%
Strongly support	585	77%
Slightly support	72	9%
Neither support or oppose	33	4%
Slightly oppose	35	5%
Strongly oppose	35	5%
Total	**760**	**100%**

Furthermore, 52% strongly support the proposal to transfer the service currently provided at Linden Lodge at Nottingham City Hospital to the NHSRC, with a further 15% slightly supporting it. In contrast, 18% either strongly or slightly oppose it and 15% neither support nor oppose this.

***Figure**: To what extent do you support or oppose the transfer of the service at Linden Lodge at Nottingham City Hospital to the NHSRC?*

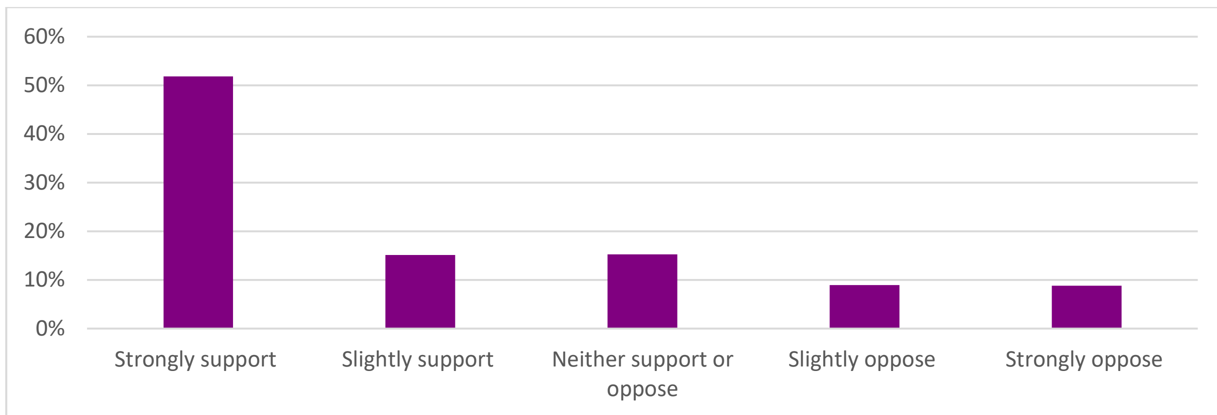


***Table**: To what extent do you support or oppose the transfer of the service at Linden Lodge at Nottingham City Hospital to the NHSRC?*

	No.	%
Strongly support	394	52%
Slightly support	115	15%
Neither support or oppose	116	15%
Slightly oppose	68	9%
Strongly oppose	67	9%
Total	**760**	**100%**

Respondents were given the opportunity to comment upon the transfer of beds from Linden Lodge to the NHSRC.

As with all open questions in this survey, responses were coded and codes grouped into themes. In many cases, it was necessary to assign more than one code to an individual's response. This method allowed responses to open questions to be represented quantitatively.

Most comments related to the accessibility of the NHSRC with the difficulty that visitors would have in travelling to the Stanford Hall Estate, particularly those reliant on public transport, being highlighted. There was concern that this would have a knock-on effect on the patients' recovery as they would receive less support from their loved ones, a vital part of the rehabilitation journey.

"This is a move away from Nottingham and Nottinghamshire, which would move patients further from their home communities. I think this will work against real rehabilitation in some ways as well as increasing difficulty of visiting for family and relative which is so vital."

"When you are in rehabilitation you need your family near you and they should be able to visit you easily, one of the best medicines is family support and contact."

In contrast, many provided a positive comment perceiving that the proposal provides an excellent opportunity to bring together all expertise under one roof – improving access to inpatient rehabilitation and patient outcomes, as well as resolving the issue of Linden Lodge not being fit for purpose.

"Linden Lodge has outgrown the building. It's too old fashioned and this is a wonderful opportunity."

“The facilities will be state-of-the-art at the NHSRC in awesome surroundings conductive to healing the mind and body.”

Alternatively, a number of individuals felt that investment should be made in the existing building/facilities at Linden Lodge and/or that the NHSRC is used as an additional facility to Linden Lodge. It was thought this latter approach would help increase inpatient rehabilitation capacity, whilst providing provision for patients with different rehabilitation needs. Other suggestions related to the provision of free parking at the NHSRC and ensuring that the NHSRC is accessible by public transport.

“I think keep both. Linden Lodge needs to remain as a local unit to maintain bed capacity and then use Loughborough to increase capacity.”

“Surely it is better to increase the provision rather than diluting the improvement by closing an already existing facility.”

“Nothing stopping the proposed model being offered at Linden Lodge. Proposed building is in the middle of nowhere. No good reason to move.”

Further comments are summarised in the table below and relate to concern about the closure of Linden Lodge which is considered to be more easily accessible and provide a high standard of care, the impact on staff who work at Linden Lodge, the importance of receiving inpatient care within local communities as well as concerns about the continuity of care for patients at the NHSRC in terms of access to specialist medical facilities (i.e. dialysis, acute care) and post discharge.

“We need these services here in Nottingham to better treat the people in the Midlands. Linden Lodge is a vital part of our NHS.”

“Movement of rehabilitation beds - in the place of maximum need and adjacent to acute trauma and neurological services to a rural location with no clear plan of how acute service links will be maintained.”

Table*: Comments on the proposal to transfer the inpatient beds from Linden Lodge to the NHSRC (N=307)*

Response theme	No.	%
Positive comments		
Development of the NHSRC	89	29%
Negative comments		
Accessibility of the NHSRC at Stanford Hall	116	38%
Closure of Linden Lodge	28	9%
Impact on Linden Lodge staff	19	6%
Local rehabilitation services are needed	16	5%
Continuity of care during the inpatient stay / post discharge	11	4%
Eligibility criteria for the NHSRC	7	2%
Excessive demand on beds at NHSRC	6	2%
Other, including: • Increased traffic around SHRE • Sustainability of a three-bedded unit at Nottingham City Hospital • Centralisation is not always best	19	6%
Considerations		
Suggestion / modification to the proposal	55	18%

Query / detail absent in the proposal	15	5%

4.2.2 Co-location with the DMRC

It was explained to respondents that;

> The NHSRC would be located at the SHRE near Loughborough - a 360-acre countryside estate which hosts the DMRC, providing rehabilitation facilities for military personnel.
>
> The DMRC would continue to operate independently and prioritise military rehabilitation, while the NHSRC would provide treatment for NHS patients only. NHS patients would be able to benefit from the state-of-the-art facilities that the DMRC has e.g. the hydrotherapy pool, the gait analysis system and the Computer Aided Rehabilitation Environment – CAREN.
>
> The location would provide peaceful, tranquil surroundings for NHS patients to focus on their rehabilitation.

Two thirds feel it is appropriate for NHS patients to be treated on the same site as military personnel (65%), with a further 22% perceiving that it is to some extent. In contrast, 8% are not sure and 5% feel it is not suitable.

***Figure**: Do you think treating NHS patients on the same site as military personnel will be suitable?*

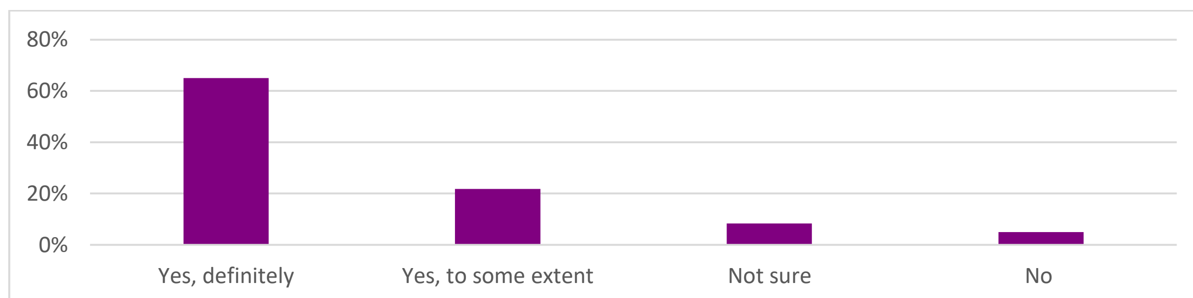


***Table**: Do you think treating NHS patients on the same site as military personnel will be suitable?*

	No.	%
Yes, definitely	493	65%
Yes, to some extent	165	22%
Not sure	63	8%
No	38	5%
Total	**759**	**100%**

The main concerns relate to the fundamental differences between these groups in terms of their mentality, needs, goals and ability to deal with adversity, as well as the increased demand that will be placed on the facilities at the DMRC, with the perception that military personnel will get priority.

“Cultural, behavioural and procedural differences can (and quite often do) create friction, confusion and divisive problems.”

“I would be interested to see how this works - I am ex-Army and set up DMRC in 2018, a lot of the facilities are used all the time during the working week so fitting in another 63 patients will be interesting.”

Additional concerns related to the site being too overwhelming and/or traumatic for some patients and the security risks associated with the co-location.

"For the community I represent - Refugees, Asylum seekers, BAME community - this will form a barrier to access, as previous traumatic experiences and other factors might limit their ability to engage."

"The security needed for military personnel/security has not been satisfactorily explained to indicate it wouldn't clash with patient need."

***Table**: Comments on the suitability of treating NHS patients and military personnel on the same site (N=38)*

Response theme	No.	%
Positive comments		
Military and NHS patients will be separated anyway	4	11%
Negative comments		
Differences between military and NHS patients	9	24%
Excessive demand on facilities / military would get priority	8	21%
Site too overwhelming / traumatic	7	18%
Security risks	3	8%
Other comments		
Location of the NHSRC	7	18%
Other comment	6	16%

4.2.3 Accessibility of the NHSRC

In terms of accessing the NHSRC at the Stanford Hall Estate, 33% feel this would be very easy and 19% easy. In contrast, 14% perceive it would be difficult, 10% very difficult, and 24% neither easy nor difficult.

***Figure**: If you wanted to visit patients at the NHSRC, how easy would this be for you?*

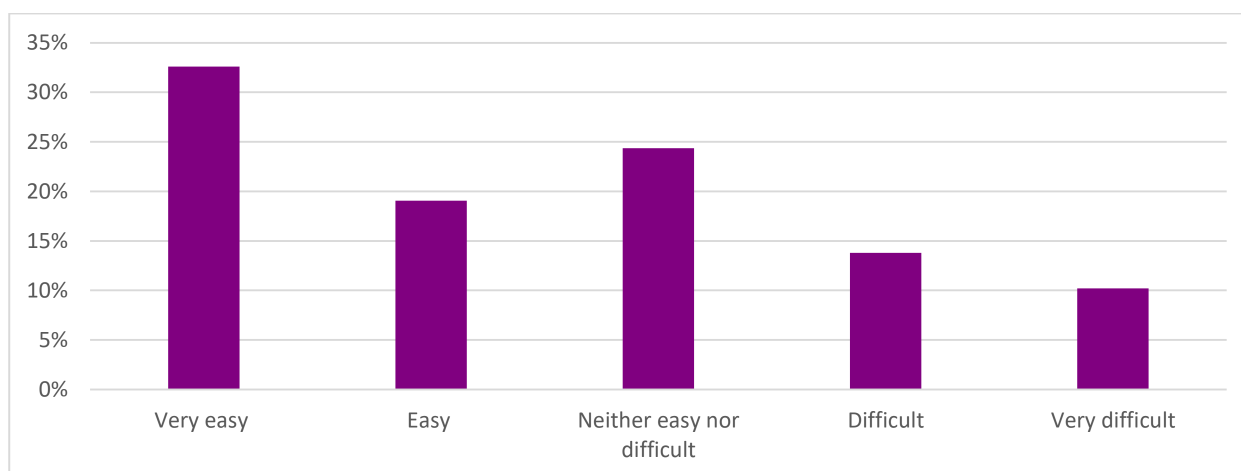


***Table**: If you wanted to visit patients at the NHSRC, how easy would this be for you?*

	No.	%
Very easy	246	33%
Easy	144	19%
Neither easy nor difficult	184	24%
Difficult	104	14%
Very difficult	77	10%
Total	**755**	**100%**

Respondents were given the opportunity to comment further upon any difficulties they might have accessing the Stanford Hall Estate.

Most comments related to concerns about the increased distance and travel time that individuals would have in accessing the Estate as well as the poor public transport infrastructure in place, which many are reliant upon.

"I live in Ashfield, the Nottingham hospital sites are already quite a distance and this would be a lot further."

"I do not drive. Public transport from north of Nottingham to Nottingham City Centre and then to Stanford Hall would be a nightmare."

However, some suggestions were put forth to help address this, these included:

- Improved public transport including re-routing of the Sky Link bus/more direct bus routes
- A shuttle bus from each hospital site
- Free park and ride schemes
- Free, and adequate, car parking facilities
- Transport links from the nearest train station
- Installation of a public footbath between Rempstone and Stanford Hall.

"As a non-driver there is no way I could access this site. My late Mother required rehab on several different occasions. She expected daily visits. I was working and had a family to look after. If I was late, never mind missed a visit, my life was not comfortable. Elderly people, in particular, expect their family to visit. So while I applaud the proposed increased benefits there needs to be proper provision for public transport."

Although it was recognised that travel to the Estate would be less of an issue for those who live close and/or have access to a car, other concerns related to the expense, the vital role that family members have in the patients' rehabilitation journey, the problems that older and/or vulnerable individuals will have as well as the safety of visitors. The latter related to concerns about security for visitors accessing the site, the safety of individuals using public transport at night, the limited pedestrian access as well as the surrounding busy roads and junctions.

"Can't imagine public transport there is great. Yet another reason to get the car out. Cycle there and risk becoming one of their patients."

***Table**: Comments on the accessibility of the NHSRC (N=228)*

Response theme	No.	%
Positive comments		
No problem for those who drive / live close	31	14%
Development of the NHSRC	6	3%
Negative comments		
Increased distance and travel time to access	59	26%
Poor public transport access to the SHRE	55	24%
Individual reliant on public transport	44	19%
Travel costs	18	8%
Not an accessible location for all	12	5%
Vital role of family in the rehabilitation process	9	4%

Access for older / vulnerable visitors	8	4%
Safety of visitors	6	3%
Other, including: • Local services are needed • Stress associated with travelling to an unfamiliar location • Impossible for respondent to travel to • Distance from hospitals	25	11%
Considerations		
Suggestion to improve accessibility	38	17%
Query, including: • Will there be free parking? • What are the plans for those who don't drive? • What public transport is available?	8	4%

It was explained to respondents that;

> To reduce the travel impact for relatives, friends and carers, it is proposed that the NHSRC would provide free family accommodation with three family rooms available, free parking as well as super-fast broadband to enable patients to keep in touch with their families via communication channels such as FaceTime and Skype. Discussions are also taking place around enhancing local public transport.

Approximately two thirds feel that these factors would help to reduce the impact of increased travel time that some might face (60%); with a further 26% indicating that they would to some extent. In contrast, 11% feel these factors would not help, whilst 3% are not sure.

***Figure**: Do you feel that these factors would help reduce the impact of increased travel time that some might face?*

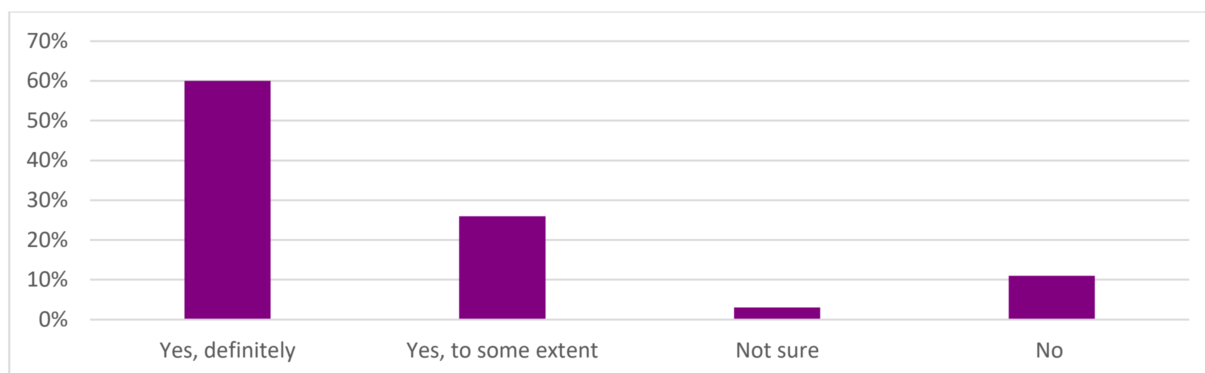


***Table**: Do you feel that these factors would help reduce the impact of increased travel time that some might face?*

	No.	%
Yes, definitely	451	60%
Yes, to some extent	196	26%
Not sure	26	3%
No	83	11%
Total	**756**	**100%**

Respondents were given the opportunity to suggest how individuals could be better supported in accessing the NHSRC.

Suggestions to improve accessibility related to:

- Improved public transport with more direct bus routes to the NHSRC
- Direct shuttle buses from each of the hospitals
- Subsidised travel i.e. discounted taxis/bus fares
- Free park and ride schemes
- A hospital car service.

In addition, a number of individuals felt that three family rooms are not adequate for 63 inpatients, with the suggestion that more should be made available.

"From personal experience - 3 will not be enough."

Other comments related to the importance of providing local services (i.e. keeping Linden Lodge open); overnight stay not being an option for some families due to work and/or childcare/caring responsibilities, the integral role that family members play in the rehabilitation process and/or the inappropriate use of NHS money being spent on family accommodation.

"It's not just transport. Many people have other caring commitments that mean they could not stay overnight."

"Feels very unfair that you can provide these perks for a vanity project like this, whilst at the same time the NHS is happy to charge patients and staff to park at NUH. I don't understand why this would be a special case."

***Table**: Suggestions to support individuals to access the NHSRC (N=80)*

Response theme	No.	%
Suggestions		
Improve accessibility	25	31%
Provision of more family rooms	17	21%
Issues / concerns		
Keep services local / Stanford Hall too far away	15	19%
Overnight stay not possible	15	19%
Regular contact with family is essential	8	10%
Inappropriate / waste of NHS funding	5	6%
Disadvantage for some (i.e. elderly who are unfamiliar with FaceTime / Skype)	2	3%
Other comments		
Other comment	12	15%

4.2.4 Benefits and concerns of the location

Respondents were asked to identify the benefits of locating the NHSRC at the Stanford Hall Estate.

Most perceived that the Estate offers a rural, tranquil setting with access to fresh air and open space - a stark contrast from that of a busy hospital environment. Many noted how this would help boost wellbeing, aiding the recovery process.

“Away from a hospital environment and in a beautiful countryside, hopefully would help with rehabilitation.”

“The estate is wonderful - overlooking open countryside, so would be tranquil and serene.”

Furthermore, respondents noted how the location provides patients with access to specialist facilities and equipment, including those at the DMRC, as well as a great opportunity for collaboration with the DMRC in terms of the sharing of resources and best practice and longer-term prospects for education, training and research.

“A purpose built environment for rehabilitation with better facilities that currently are on offer at Linden Lodge.”

“Cross-fertilisation of experience with established military state-of-the-art facilities.”

A smaller number perceived the location to be centrally located in the East Midlands region, as well as in the UK, and accessible by car and public transport.

“It’s in a central location with good road networks and trains.”

Others highlighted the benefits associated with having all rehabilitation expertise in one location.

“Critical mass of resources and well resourced.”

Further benefits, some of which reflect the wider proposal for a NHSRC, included improved access to focused rehabilitative care, reduced demand on acute NHS services, NHS savings through the utilisation of available land and better patient outcomes, and the pro-rehabilitation culture and ethos that will be embedded at the NHSRC.

“Allowing the NHS to use existing facilities and services at Stanford Hall would enable this area to have a centre of excellence without duplication. Financially it would be an investment to support both patients and staff.”

“It would be good to have a larger pool of patients going through similar journeys and a peer support and it may help from a psychological perspective.”

***Table**: Benefits of the location (N=594)*

Response theme	No.	%
Rural, tranquil setting	252	42%
Access to facilities/equipment inc. those at the DMRC	196	33%
Collaboration and shared learning with the DMRC	143	24%
Good accessibility	82	14%
Centralised service	72	12%
None/negative comment	53	9%
Improved access to specialist, focused rehabilitative care	35	6%
Reduced demand on acute NHS services / increase in the number of beds	32	5%
NHS savings (through shared costs and better patient outcomes)	16	3%
Pro-rehabilitation culture and ethos	15	3%
Other benefit / comment, including: • Provision of family accommodation	64	11%

• Local economy boost/job opportunities • Much needed improvement from Linden Lodge		

In terms of concerns of the location, over half of those that responded to the question cited this to be travel and accessibility, an issue relevant for both visitors and staff. Concerns related to the increased travel time from Nottingham and other areas, the cost and poor public transport access.

“Concerns about accessibility - not on a bus route, away from a train station, harder for those without vehicle access.”

“Distance from Nottingham, accessibility issues particularly for those who don’t have transport or are elderly.”

Although some did make a positive comment or felt there are no issues, others commented upon:

- Stanford Hall’s poor geographical position within the East Midlands region.
- The impact on patients’ wellbeing if they are unable to see their loved ones on a frequent basis.
- Conflict between the DMRC and the NHSRC in terms of the shared use of facilities, with concern that the military personnel get priority, as well as the issues associated with dealing with two very different population cohorts and the potential for inequalities in treatment to be highlighted.
- Reduced continuity of care beyond inpatient stay due to the distance of the location from acute hospitals, with concern about what would happen in cases of emergency.
- The impact on the surrounding area at Stanford due to the increased volume of traffic, which many already identified to be a problem.

“Find a location more central.”

“I imagine a lot of patients will end up being far away from home and this can have repercussions for mental health, wellbeing and relationships with family. Particularly for those who live far away.”

***Table**: Concerns about the location (N=569)*

Response theme	No.	%
Travel and accessibility	316	56%
None/positive comment	124	22%
Poor geographical position	52	9%
Isolation of patients	48	8%
Sharing/conflict with DMRC	33	6%
Continuity of care/distance from other NHS specialties	32	6%
Impact on surrounding area	23	4%
Limited access to community amenities for rehabilitation purposes	18	3%
Security of the site	16	3%
Continuity of care post discharge/no outpatients service	13	2%

Safety of travelling visitors (i.e. busy roads/junctions, limited pedestrian access)	11	2%
Impact on Linden Lodge staff	9	2%
Other concern/comment, including: • Referral & eligibility criteria • Location too intimidating • Recruitment of staff • Loss of service at Nottingham City Hospital • Difficulty of home visits • Lack of other inpatient rehabilitation options • Proposal assumptions • Financial concerns • Difficulty for families to be part of the process • Inadequate family accommodation	76	13%

4.2.5 Treatment and care at the NHSRC

Respondents were informed that;

> The NHSRC will take a fresh and innovative approach to rehabilitation, putting the patients at the centre of care.
>
> - It would be staffed by a multi-disciplinary team consisting of rehabilitation consultants, orthopaedic consultants, therapy assistants, physiotherapists, mental health nurses, occupational therapists, speech and language therapists, social workers and other professionals as needed.
> - There would be a focus on occupational and vocational rehabilitation to help people get back to work.
> - Each patient would be assigned a dedicated person (a clinical case manager) to coordinate their care throughout – from referral through to discharge.
> - There would be an increase in the number of hours of therapy per patient per week (one-to-one and group sessions), with patients being able to spend their additional time on the rehabilitation estate supported by occupational and vocational therapists.
> - Patients would have access to facilities such as a gym, hydrotherapy pool and a system to help patients practice their mobility and balance on a range of different services.

Most described the care that patients would receive at the NHSRC as excellent (73%), with 17% perceiving that it would be very good. Furthermore, 7% stated that it would be good, 1% fair and 1% poor.

***Figure**: What are your thoughts about the care that patients would receive at the NHSRC?*

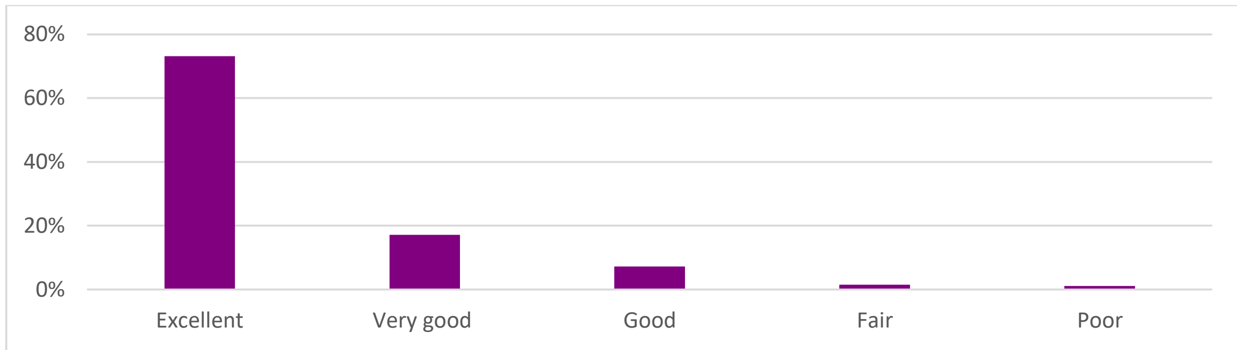


***Table**: What are your thoughts about the care that patients would receive at the NHSRC?*

	No.	**%**
Excellent	550	73%
Very good	129	17%
Good	54	7%
Fair	11	1%
Poor	8	1%
Total	**752**	**100%**

Two thirds feel that the range of health and social care professionals that patients would have access to at the NHSRC is excellent (66%). Furthermore, 21% perceive this to be very good, 7% good, 4% fair and 1% poor.

***Figure**: What are your thoughts about the range of health and social care professionals that patients would have access to at the NHSRC?*

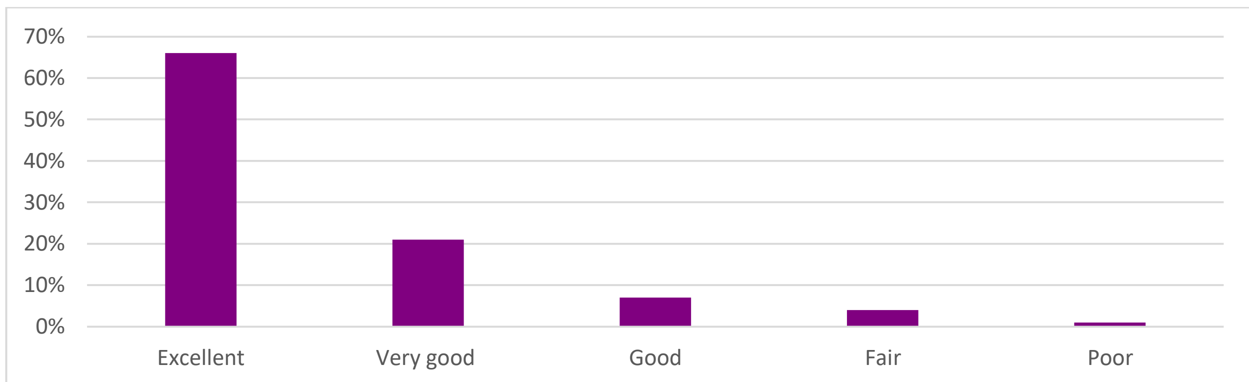


***Table**: What are your thoughts about the range of health and social care professionals that patients would have access to at the NHSRC?*

	No.	**%**
Excellent	499	66%
Very good	160	21%
Good	54	7%
Fair	27	4%
Poor	11	1%
Total	**751**	**100%**

The following was explained to respondents;

> We recognise that it is important that patients' mental wellbeing is equally considered alongside their physical rehabilitation. It is therefore essential that proposals for the NHSRC take mental health, particularly helping patients to avoid feelings of isolation and boredom, into consideration. This will be done in relation to:
>
> - The way in which clinical and other staff will help patients create an environment of support, helping to minimise any feelings of social isolation.
> - Making assessment of patients' mental health part of ongoing assessments at least three times a week.
> - Support provided by a mental health nurse.
> - The design of the social facilities and use of the grounds. Evidence suggests that 'green spaces' are linked to improvements in patient wellbeing, mental health, levels of stress and positive behaviours.

The majority feel confident that patients' mental health is being taken into account (72%). However, 22% perceive it is being taken into account but more could be done and 7% that more needs to be done.

***Figure**: What are your thoughts on the approach to managing the mental wellbeing of patients during their time at the NHSRC?*

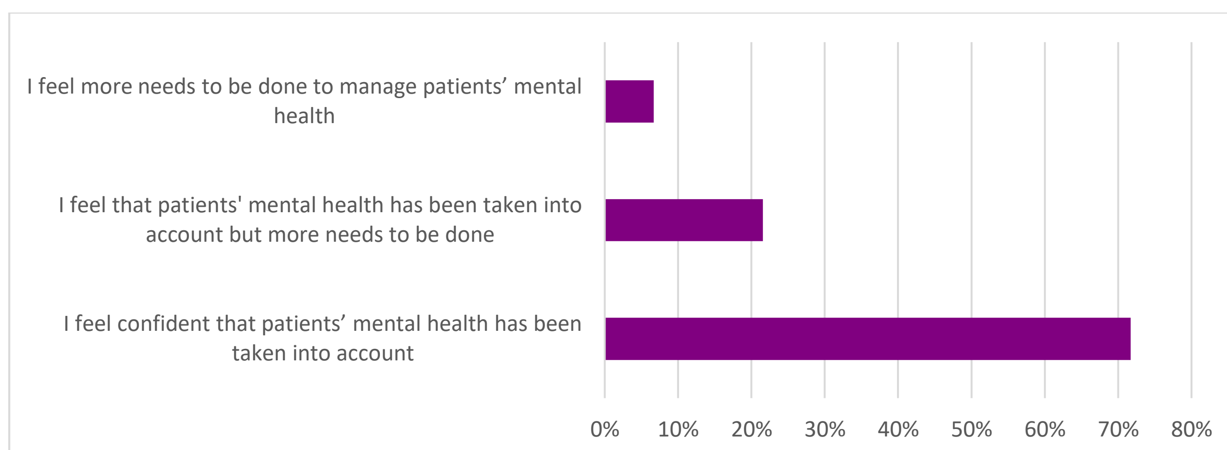


***Table**: What are your thoughts on the approach to managing the mental wellbeing of patients during their time at the NHSRC?*

	No.	%
I feel confident that patients' mental health has been taken into account	535	72%
I feel that patients' mental health has been taken into account but more needs to be done	161	22%
I feel more needs to be done to manage patients' mental health	50	7%
Total	**746**	**100%**

Respondents were given the opportunity to provide any further suggestions as to how they thought patients' mental health could be better managed.

Most comments related to the need for greater support for patients due to the complexity of their needs, with suggestions that the following professionals should be included in the staff mix:

- Mental health occupational therapist
- Neuropsychiatrist
- Clinical psychologist/neuropsychologist/counselling psychologist/pain psychologist/psychologist
- Registered general nurse with mental health training
- Counsellors
- Activity coordinator.

"The correct professionals need to be involved. Mental health nurses may not be trained in the psychological impact of health conditions, mental illness is rare in this group."

Major injury is life changing where are your clinical psychologists, activity coordinators and psychiatric team? A nurse asking if you are ok isn't good enough especially if you can't physically be with your family. Just look at lockdown a few face time calls isn't the same."

Furthermore, incorporation of a range of therapy options was also considered important:

- Cognitive behavioural therapy
- Garden therapy
- Acceptance and commitment therapy
- Music therapy
- Art therapy
- Family-centred mental health practices.

Other suggestions included maximising the involvement of friends and family through improved access, providing access to mental health services post discharge, having a space for patients to socialise, providing opportunities for patients to explore the local community, inclusion of and mental health support for family members, provision of functional activities and ensuring that regular, meaningful assessments are undertaken.

"Anyone can be trained to ask questions, it's what you do afterwards. Mental health nurses unless extremely experienced in physical and mental health in combination will not add that value as many do not understand their interconnection."

A number of other comments/issues were raised including the importance of taking mental health seriously, not just playing it 'lip service', and the need for patients to be treated within their local community.

***Table**: Suggestions to help manage patients' mental health (N=139)*

Response theme	No.	%
Suggestions		
Greater support needed through the involvement of other professionals and different therapy options	62	45%
Maximise involvement from friends & family through better access	13	9%
Access to mental health support post discharge	6	4%
Space for patients to socialise	5	4%
Opportunity for patients to explore the local community	5	4%
Inclusion of and mental health support for family members	4	3%
Provision of functional activities	4	3%
Regular, meaningful mental health assessments	4	3%
Information Hub	1	1%
Issues / concerns		
Remoteness and boredom associated with location	12	9%
Mental health must be taken seriously (implication for funding and staff training)	11	8%
Patients must be treated within their local community / local services needed	4	3%
Query over access for patients detained under the MHS or have MOJ restrictions	2	1%
Other comments		
Other comment	24	17%

4.2.6 Other comments/considerations

A wide range of other comments and considerations were made by respondents, these are summarised in the table below.

***Table**: Other comments (N=321)*

Response theme	No.	%
Positive comments		
Great opportunity/beneficial	133	41%
Issues / concerns		
Local services needed/don't close Linden Lodge	21	7%
Location of the NHSRC at Stanford Hall	10	3%
Financial sustainability/perception - cost saving initiative	10	3%
Capacity inadequate to cope with regional demand	6	2%
Criteria inappropriate to meet existing needs of rehabilitation referrals from acute hospitals	6	2%
Impact on Linden Lodge staff / recruitment difficulties	5	2%
Decision has already been made / consultation a tick-box activity	4	1%
Lack of local rehabilitation options for those not eligible to access the NHSRC	4	1%
Issues with running NHSRC alongside DMRC / careful thought needed	4	1%
Impact on the local area (Stanford)	2	1%
Issue of mixing patients with differing needs	2	1%
Considerations		
Access for other patient cohorts, including: • Children / those aged 16+ • Those with spinal injuries • Stroke patients • Other causes of limb amputation • Complex polytrauma patients	38	12%

• Non-trauma patients (i.e. oncology, knee replacement) • Tracheostomy / ventilator dependent patients • Medically discharged patients with continuing rehabilitation needs		
Adequate staffing required with additional support / services, including: • Neuro specific staff • Psychologist • Dietician • Chaplain • Orthotist • Dog/art/music/recreation therapy • Access to BSL interpreters.	24	7%
Request for more information in relation to: • Timescales • National or local facility? • Long-term funding plan • Referral criteria and pathways • How available the facilities at the DMRC will be/how will patients be transferred to these facilities • Occupational therapist interventions • Length of stay • Discharge management and local step-down provisions • Medical specialties at the NHSRC • Evidence to support the proposed model.	24	7%
Accessibility of the NHSRC must be improved	13	4%
Development of existing community rehabilitation provisions	10	3%
Referral pathways and equity in access from all local areas	8	2%
Mental health support is imperative, including family support	6	2%
Links to charities/other organisations to support community integration/return to work/discharge	4	1%
Strong links with social care	2	1%
The NHSRC must deliver on promises	4	1%
Other comments		
Other comment	30	9%

5 Feedback from the focus groups

A total of ten individuals participated in the online focus groups and one-to-one telephone interviews. The reasons for the interest of these individuals are shown in the table below. A summary of this feedback is provided in Section 5.5.

Table: *Focus group / interview participants*

Interest	No.
NHS staff member/health professional	3
Past specialist rehabilitation inpatient	3
Representative from an independent organisation supporting neurological patients	1
Representative from a charitable organisation supporting neurological patients	1
Carer of a past specialist rehabilitation inpatient	1
Member of the public accessing outpatient care at Linden Lodge	1

5.1 Benefits of the proposal

Participants identified many benefits of the proposal, not only to patients, but in terms of improving the delivery of rehabilitation services across the East Midlands. These included:

- Development of a purpose-built rehabilitation facility for NHS patients with expertise under one-roof
- Improving patient access - addressing the large gap in provision for multiply-injured patients
- Improving access to up-to-date treatments, including the state-of-the-art facilities at the DMRC
- Collaboration and shared learning with the DMRC.

“There has been a massive gap in provision for multiply-injured patients for many years, so I welcome it for them. We aren’t able to provide the rehabilitation that they need in an outpatient setting.”

“It is a phenomenal opportunity for the NHS to bring all of that expertise across rehabilitation to one place. The military centre is obviously state-of-the-art, in terms of their technology/facilities and there are lessons to be learnt probably both ways.”

The proposal was also felt to provide a great opportunity for Lincolnshire patients who frequently have to travel out of the area to receive specialist care, due to the lack of local facilities available to them.

“We are extremely interested in the proposal because services in Lincolnshire are very poor and we are interested in how our patients can benefit from something locally. Our patients are used to going out of the county for care.”

Furthermore, one participant described how she felt the current inpatient facility at Nottingham City Hospital was not fit for purpose, perceiving that the lack of facilities available hindered her brother's recovery.

"The staff were very good but it was like a small prison due to the lack of facilities. We had to take our own TV in for him. It needs knocking down; it is not fit for purpose."

This individual described how her brother only received 45-60 minutes a day of intense rehabilitation during his two inpatient stays and therefore perceived that a more intensive rehabilitation programme would be extremely beneficial.

"His recovery could have been quicker if he had received physiotherapy/occupational therapy support like in the stroke unit whereby patients receive intensive, daily physiotherapy and occupational therapy sessions leading to a speedier recovery and a reduction in time in hospital of three days on average."

A small number commented upon the location of the NHSRC at Stanford Hall and the benefits that this will bring to patients in terms of health and wellbeing.

"It's a super opportunity. Linden Lodge has a small patio area, so the ability for patients to get outside and have some fresh air at the NHSRC would be fantastic."

5.2 Concerns about the proposal

In contrast, a number of concerns were raised about the proposal, many of which related to its location at the Stanford Hall Estate.

5.2.1 Poor accessibility

Many felt the location would be difficult for visitors to access, particularly those who don't drive and rely on public transport as well as those who have other day-to-day commitments e.g. work and childcare / caring responsibilities.

"For those relying on public transport it will be very difficult."

"I lived with my parents when I had my accident, for them having to travel to Loughborough would have been a big problem as they both worked full time."

Difficulty in access was felt to have a knock-on effect upon the frequency that patients could see their family/friends, potentially contributing to feelings of low mood and/or depression.

"Not being able to see your family is exceptionally hard and contributes to the mood swings and depression."

Although super-fast broadband was perceived to help some families to keep in touch, it was noted that many patients would be unable to use technology such as FaceTime and Skype.

Whilst the provision of accommodation for family members was felt to mitigate the travel issues that some might face, three rooms was felt to be insufficient given the centre's 63-bed capacity. It was further recognised that for various reasons including work and childcare/caring responsibilities, staying at the centre would not be an option for some.

"Three family rooms are great but I imagine there will be a huge demand for them."

"What about the families that can't stay? These patients are likely to be there for many months."

A suggestion was made by the participants that a shuttle bus service is provided from the various hospital sites to improve accessibility.

5.2.2 Segregation from society

Comments were made about Stanford Hall Estate being segregated from society with concerns about the impact that this will have on the patients' rehabilitation process. Participants in one focus group suggested that there should be cafes, shops and other facilities within the NHSRC to make the environment 'more normal' and allow patients to practice these day-to-day activities.

"They so love to go Costa, to get away from the ward and get outside, they love to speak to each other and see a wide range of people, they don't want to see the same faces."

5.2.3 The involvement of relatives in the patients' rehabilitation journey

There was concern that the remoteness of the location would create difficulty for family members/carers to be involved in their relatives' rehabilitation journey. This was felt to be particularly important given the vital role that these individuals play in the patients' wellbeing throughout the rehabilitation process and beyond.

"Patients need to have links with their families and they need to be maintained."

One health professional explained how much of a shock it can be to family members when they realise how impaired the individual actually is.

5.2.4 Access to medical specialties and continuity of care

Questions were asked about the medical facilities and specialties that will be available at the NHSRC to deal with patients' complex medical needs and how patients will access specialist care, which isn't available in the centre.

"While in Linden Lodge, my brother had appointments for haematology and ophthalmology as well as repeated lung function tests, either myself or a staff member would take him for these."

Discussions regarding inpatients who suddenly become unwell and require acute care, led to concerns as to what would happen in these situations and whether the receiving emergency departments will have the expertise available to deal with the patients. This was identified to also have implications on staffing at the NHSRC as patients would have to be accompanied by a member of staff.

"I collapsed when at Linden Lodge and had to be taken back to intensive care, what will happen in cases of emergency?"

There was a great deal of uncertainty as to whether patients would be able to receive the same seamless care as they do currently at Linden Lodge, due to the distance of Stanford Hall Rehabilitation Estate from hospital settings.

"It's the links to the hospitals and how that is managed for communication purposes."

"I was admitted to intensive care in Queens Medical Centre and then the acute neuro ward. I was seen by a Senior Physiotherapist from Linden Lodge who put in place the

start of my rehabilitation process. I was then transferred to Leicester for a short while, the specialist brain unit. I was concerned about the fracturing of care, but everyone kept in touch, so when I came back from Leicester I had seamless care and everyone was made available to me."

5.2.5 Discharge of patients to their local communities

Many questioned how the discharge process would work and further how the distance of the NHSRC from some counties might impact on this.

"We would normally invite a member of the local community neuro teams to case reviews – the distance may not allow that to happen."

"The reablement team, the transition between inpatient and outpatients – will there still be a reablement team to support you to settle back home?"

Additionally, it was asked what 'step-down' rehabilitation is available within communities to continue to support patients in their rehabilitation journey, with concern that the lack of provision available will reverse the benefits of the intensive rehabilitation.

"Even if we have this development, the step-down after that, when people go into their local areas – where is the step down rehab within communities, is it going to undo the benefits of the intensive rehab?"

Participants in one focus group positively discussed the idea of a rehabilitation flat to support patients in becoming more independent prior to their discharge. A suggestion was made that the CCG should explore opportunities to collaborate with the independent sector which already provides similar facilities.

"We provide flats which support the discharge process primarily for neurological patients. One of the things we have found is that, post-brain injury – the person is going home with a different skill set, needs and sometimes a different personality. It's important that when the family is having to support that individual at home that they can all practice together with professionals around to iron out any wrinkles before they are left to go it alone."

5.2.6 Criteria for admission and the referral process

Participants repeatedly questioned who would be eligible for treatment at the NHSRC, with concerns about what would happen to those who weren't eligible or chose not to receive their care there.

"What will happen to those who can't receive care at the NHSRC, what will be available for them?"

Clarification was sought upon the criteria for MSK patients, with one health professional stating that most major trauma patients who need MSK rehabilitation go home directly from the major trauma centre and receive their rehabilitation within the community. The same health professional highlighted how once medical co-dependencies has been investigated, the patient cohorts that can be safely treated at the NHSRC will be limited.

"There are multiple specialties you would have to have on site."

Furthermore, questions were asked about the referral process and how equity in access will be ensured, with concerns about how accessible the service will be for Lincolnshire patients.

"It may be that those consultants who shout the loudest get the majority of access to the unit, so there may be people whose consultant isn't able to get them access or they may be unaware of what is available there."

"How will our (Lincolnshire) patients be able to access the service? If connections aren't made between hospitals then there is nowhere for our patients to go. I don't think we've had any patients attend Linden Lodge, which is interesting in itself, will this new facility push us out even further?"

5.2.7 Financial issues

A small number expressed concern as to whether £70 million is sufficient to build what is being proposed and furthermore whether the CCG will have enough money to fund the facility day-to-day.

"£70million doesn't sound enough to me, to adapt what is already there and to build what is needed for the number of patients it seems inadequate for what they want to do. I'm concerned that when they see the final bill they will realise it's twice as expensive as they thought and that it will finish up being a poor man's service not the top notch one they wanted it to be."

One individual described the proposal as a 'fantasy' given that whilst patients are 'bed blocking' in acute NHS services they don't receive intensive physiotherapy/occupational therapy whilst they are waiting, and therefore there isn't a cost that can be transferred.

5.2.8 Workforce issues

A handful of comments were made regarding staffing and whether the CCG will be able to recruit the specialist staff required, given the workforce issues that are currently being experienced. These issues were highlighted by a past inpatient who stayed at Linden Lodge earlier this year/during the Covid-19 lockdown;

"We had nights were there wasn't sufficient staff and they had to get bank staff at short notice."

Furthermore, a small number questioned whether staff are happy about being relocated/travelling to the new development.

5.2.9 Other issues

Other concerns, identified to a lesser extent, related to:

- The differences between rehabilitation care for military personnel and NHS patients.

"It's a job, place of work, some military personnel who don't have cognitive deficit arrive on a Monday morning and go home at the end of the week."

"Statistics are being compared to the military and their approach is very different."

- Patient safety - ensuring that security is in place for access as well as precautions to prevent patients from absconding.

- Participation in intensive rehabilitation being more dependent on patients' physiological ability i.e. fatigue, rather than their willingness and motivation.

"I know from my own condition, fatigue was a huge thing. I'd manage half an hour before they had to put me to bed."

5.3 Mental wellbeing of patients

Mental health support was perceived as vitally important for patients at the NHSRC, and their families, to help them to come to terms with what has happened, as well addressing any feelings of low mood or isolation that may be associated with being at the centre.

"The psychiatric consultant was invaluable in supporting my brother at Linden Lodge and us as a family."

"If you are going to isolate patients and they don't have visitors from one week to the next, it will be so important."

Participants emphasised that support must be available from a wide range of mental health professionals including psychiatrists and psychologists, that it must cover a range of specialisms and that it must be very accessible to patients.

"You have psychologists for neuro with brain injury, neuro without brain injury, then there is the psychology for people with major trauma, that psychology is completely different to that of feeling isolated."

One individual explained how disengaged she was with the psychological support that she received during her inpatient stay at Linden Lodge, noting how she would have found the support more valuable post-discharge.

"Seeing a psychologist every week, I would pretend to be asleep, I didn't want to engage. It didn't really work, I didn't think it was important; I just wanted to get up and walk. I would have benefitted from having access to a psychologist after I left."

Participants made a number of suggestions to help to ensure that patients are kept occupied and motivated during periods of down-time, particularly if their relatives aren't able to see them as frequently:

- An information hub – a place where patients can go and ask any questions they might have or find out information.

"Somewhere people can go and ask questions about anything. People don't expect to be in rehabilitation, it is difficult to navigate the system, the pathways, the jargon, the 'what happens next' – all those worries and anxieties can play on your mind – it would be great if they had somewhere to go and ask a question"

- Peer support – using those who have been through intensive rehabilitation to provide support to those currently on their journey.

"There is great value in talking to people who have been there before, to share experiences."

- Giving patients access to iPads and other devices with quizzes and other interactive games.

"Interactive things are better than talking to a professional. It's nice to have reassurance that you still know some things."

5.4 Other queries/points for consideration

- What will happen to the site at Linden Lodge? What will happen to the building? Will outpatients be expanded?
- What measures will be in place if the facilities at the DMRC are fully subscribed/needed by the military and therefore access for NHS patients is limited?
- How will it work with pharmacy, given that neurological patients need speedy access to medication?
- How will patients be supported to return to work when they aren't necessarily in that mind-set or consider that a priority in their rehabilitation journey?
- How will the three-bedded service that remains at Nottingham City Hospital operate as a dedicated rehabilitation unit?
- How will the NHSRC link with social services?

5.5 Summary

Participants identified many benefits of the proposal, the key ones being:

- Development of a purpose-built rehabilitation facility for NHS patients with expertise under one-roof.
- Improved patient access - addressing the large gap in provision for multiply-injured patients.
- Improved access to up-to-date treatments, including the state-of-the-art facilities at the DMRC.
- Collaboration and shared learning with the DMRC.

In contrast, a number of concerns were raised, many of which related to the NHSRC's location at the Stanford Hall Estate:

- Difficulty in access for visitors – particularly those who don't drive and are reliant on public transport as well as those with other day-to-day commitments.

- Feelings of low mood and/or depression associated with patients seeing their family/friends less frequently.

- Segregation from society, with concern that patients won't be able to practice normal, day-to-day skills which are an essential part of rehabilitation.

- Difficulty for family members/carers to be involved in their relatives' rehabilitation journey.

- Reduced access to medical specialties, including acute care, impacting upon patients' continuity of care.

- Distance of the NHSRC from local communities and the impact this has on the transition from inpatient to community care.

- Availability of step-down care within local communities, with concern as to whether this will be adequate enough to continue to support patients in their rehabilitation journey.

- Options available to those who are ineligible to receive their rehabilitation care at the NHSRC or chose not to.

- Financial modelling and sustainability of the new facility.

- Recruitment of specialist staff as well as opinion of those currently working at Linden Lodge.

6 Feedback from stakeholders

To ensure as fair an opportunity as possible was given for all to provide a contribution to the consultation, direct communications were actively encouraged and included in the process.

A summary of this feedback is provided in Section 6.6.

***Table**: Responses received from stakeholders and via social media*

NHS Trusts	• Nottingham University Hospital • University Hospital of Leicester • University Hospitals of Derby and Burton
CCGs	• NHS Leicester, Leicestershire and Rutland • NHS Derby and Derbyshire
Professional bodies / associations	• The British Society of Rehabilitation Medicine • Rehabilitation Medicine Specialist Advisory Committee • Royal College of Physicians • The Paediatric Neuroscience Governance Council
Charity organisations	• Healthwatch Lincolnshire • Headway
Social media	• Facebook

6.1 Submissions from NHS Trusts

6.1.1 Nottingham University Hospital NHS Trust Board

A response was received from the Chief Executive Officer and Chairman of the Trust Board on the 4th September 2020.

The response emphasised the Trust's continued support for the proposal, specifically in terms of:

- The benefits that would be brought to the patient population, recognising that many patients in acute beds require rehabilitation to regain a fulfilling life
- The increased access to specialist inpatient rehabilitation
- The transformation of how rehabilitation is delivered across the system, setting a blue print for others
- The significant health and social care savings associated with patients' improved outcomes
- The opportunity to deliver a national centre of excellence which creates further opportunity for local public sector collaboration in the areas of education and research.

6.1.2 University Hospitals of Leicester NHS Trust

A response was received on the 17th September 2020 from the Acting Chief Executive of the University Hospitals of Leicester NHS Trust.

The response details that the Trust fully support the proposal as it provides opportunity to not only reduce the demand on acute and community services, but also for the region in hosting such a prestigious flagship centre. The Trust is also enthused by the involvement of the University of Leicester, which will form part of the academic consortium, and further the positive influence of the NHSRC to other areas of the country.

"The East Midlands has been presented with a golden opportunity to deliver a national centre of excellence which will greatly benefit our patients and creates further opportunity for local public sector collaboration in the areas of education and research."

6.1.3 University Hospitals of Derby and Burton NHS Trust

An extensive response was received from the Rehabilitation Medicine Department of University Hospitals of Derby and Burton NHS Trust. It states that the Department 'neither supports nor opposes' the proposal for the development of the NHSRC and further that they 'slightly oppose' the transfer of the service at Linden Lodge stating that neurorehabilitation services in Nottingham will be in a poorer state from this. The main reasons for their objections are summarised below:

- NHSRC patients will lose the benefits of easy access to urgent care and diagnostics, as well as to specialist physicians/surgeons. They will therefore not have continuity of care beyond inpatient stay, which is standard in all neurorehabilitation units.

- The NHSRC is much less accessible than Linden Lodge and will be difficult, time-consuming and costly for those travelling by public transport.

- The remoteness of the SHRE does not allow patients to practice 'real world' situations.

- Managing split sites (i.e. the NHSRC and the three bedded facility at Nottingham City Hospital) will be costly and difficult.

- The significant number of patients who would normally be in a level 2b inpatient unit who will be ineligible to receive care at the NHSRC, with the Department questioning where those patients would go other than the three acute neurorehabilitation beds remaining at Nottingham City Hospital.

  The Department noted that in a typical neurorehabilitation ward at least a third (of patients) are not compatible with the ethos of the ideal NHSRC patient cohort. It is therefore felt that there will be two cohorts of patients with different rehabilitation needs.

The Department strongly emphasises that a dynamic outpatient service is a must for the success of the NHSRC. Their argument is provided on a number of reasons:

- The current proposal is not compatible with research, innovation and training, primarily because patients need to be engaged with over a longer term.
- There will be two types of patients needing vocational rehabilitation at the NHSRC - MSK patients and neurorehabilitation patients, which for differing reasons would require ongoing input post discharge.
- Complex prosthetics is unlikely to be relevant to inpatient stays for MSK patients – these are longer term issues, which only an outpatient service will deal with.
- It is assumed that patients will be sent back to local rehabilitation services for therapy and medical follow-up; however the reality is that they could be waiting for many months before they are picked up.
- For neurorehabilitation patients, typically the immediate and discharge goal is to help them to manage in their home environments. Therefore, facilities such as Gait analysis, CAREN and the hydrotherapy pool are more beneficial for neurorehabilitation patients in the longer term than during their inpatient stays.
- Access is needed to a wheel chair service, which either needs to be subcontracted to a regional service or the NHSRC has its own in-house service. Due to the distance, it will be difficult for the regional service to provide timely input.

The Department therefore urges that these issues are considered before moving forward to make the project successful.

The response also highlighted a number of further points for consideration, including:

- Inclusion of other types of professionals within the skill mix i.e. neuropsychologists (to provide cognitive and behavioural assessments), psychiatrists, orthotists and general physicians.
- Safeguarding measures for ‘wandering’ patients.
- Suitability of high intensity therapy for patients - physical and cognitive fatigue.
- Unrealistic lengths of stay within the Pre-Consultation Business Case and Workforce document.
- The NHSRC should employ the whole of the consultant workforce to allow negotiation with trusts and ensure all consultant staff are guided by the same set of regulations, managerial structures and training requirements.
- Inadequacy of three family rooms for 63 inpatients.

- Super-fast broadband may benefit some, for others it will be of no use.
- At times of major conflicts, NHS rehabilitation beds may be absorbed by the DMRC.

6.2 Submissions from Clinical Commissioning Groups

6.2.1 NHS Derby and Derbyshire CCG

A response was received from NHS Derby and Derbyshire CCG (DDCCG) on the 17th September 2020.

In principal, DDCCG considers the proposal to increase the number of rehabilitation beds within the East Midlands - a positive step for improving patient outcomes and meeting the existing unmet demand.

However, DDCCG has concerns about the location of and access to the service. Their response highlights that the calculations included within the travel impact assessment (TIA) do not cover the new DDCCG boundary, meaning it is likely that visitors will have to travel even further than that documented in the TIA.

In addition, the DDCCG has a number of specific queries in relation to;

- The extent to which clinicians from the relevant team at UHDB have been involved in constructing the proposal.
- Wrap around services and the impact on the community offer that would need to support patients who are discharged from the NHSRC.
- Equity of care for patients who receive their rehabilitative care at the NHSRC vs the Kings Lodge site, as well as an assessment of impact that the NHSRC would have on the Kings Lodge service.
- The route of referral and whether those under a legal framework, such as the Mental Health Act or Ministry of Justice restrictions, can access the service.
- The extent to which the development gives equal consideration to the mental health needs of the patient cohort.
- Validity of any assessment / outcome tools devised by the service.
- Arrangements to manage the quality of service.
- Assumptions which underpin the length of stay and non-elective admission efficiencies that have been applied for Derby and Derbyshire demand.

6.2.2 NHS Leicester, Leicestershire and Rutland CCG

A response to the consultation was received from Leicester, Leicestershire and Rutland (LLR) CCG.

The response explains how the proposal does not fit with LLR's Home First Strategy, the premise of which is that keeping patients in a hospital environment is not positive for their general health. Heavy investment has recently been made in outpatient rehabilitation, with LLR CCG now looking to improve day case rehabilitation services, not inpatient services.

As LLR does not have its own trauma centre, LLR CCG has little need to refer patients to a rehabilitation centre. Furthermore, a review has revealed that LLR CCG has small numbers of neurorehabilitation patients who would require this type of facility.

For stroke patients, LLR CCG has a cohesive acute and community team delivering rehabilitation to this patient group, with the services based around outpatient / home visits.

For these reasons, LLR CCG is not able to support the proposal, however if a day case model was to be considered they may be able to support it.

6.3 Submissions from Professional Bodies/Associations

6.3.1 The British Society of Rehabilitation Medicine

A response was received on the 17th September from the British Society of Rehabilitation Medicine (BSRM).

The response states that the BSRM strongly support the creation of the NHSRC, however has many reservations about its location at the Stanford Hall Estate, and further that they strongly oppose the transfer of inpatient beds from Linden Lodge. The key reasons for this are summarised below:

- Patients requiring inpatient specialist rehabilitation have multiple and complex needs, medical safety for these patients can only be assured by the co-location with those specialties that are most commonly needed on an acute basis.

  Concern was raised about the high proportion of patients currently receiving rehabilitation at Linden Lodge who need prompt access to acute medical and supporting services, which are not available on a stand-alone site.

"Patients are therefore likely to be selected for rehabilitation at the NHSRC on the basis of predicted low medical needs, rather than true rehabilitation need."

- Transfer of patients from the NHSRC to Nottingham City Hospital for investigations or acute care will require availability of additional staff.

- The significant lack of detail regarding medical cover raises concern as to whether the out-of-hours medical support will have the expertise to assess acute illness in complex rehabilitation patients. Further concern was raised about the processes for acute medical management, and how this will be delivered safely.

- The Stanford Hall location is reminiscent of the historical practice of ‘convalescence’ in a rural location, rather than active rehabilitation in an urban environment, close to patients’ homes.

- Public transport to Stanford Hall is inadequate with concerns about the safety of visitors travelling to the site, as well as the additional journey time and cost.

- Social isolation from family and friends will pose huge issues, with the potential for patients to become estranged from their families. Superfast broadband will only be useful to those who can use this technology.

- Home visits to facilitate discharge will prove time-consuming and costly in terms of staff time and in provision of transport.

- Three rehabilitation beds at Nottingham City Hospital will not meet the actual need for early rehabilitation following illness or injury.

- Training requirements for rehabilitation medicine trainees could not be fulfilled at the NHSRC, with the likelihood that the site will not be approved for the training of specialty trainees.

It is therefore felt that the NHSRC would be valuable as a tertiary service for specific circumstances, where there is currently inadequate and/or non-expert provision. These patients would be medically stable and won’t require acute medical care during their rehabilitation programme. Example cohorts of patients with chronic and debilitating pain, sports rehabilitation or patients who have suffered complex polytrauma were provided.

The response also highlighted a number of further points for consideration;

- Rehabilitation goals and aspirations of NHS patients are not comparable with those of military personnel.

- Unaccounted demand by patients who are not currently occupying beds, but have unmet rehabilitation needs.

- Three family rooms are inadequate for 63 patients.

- Many patients will initially only be able to tolerate rehabilitation/therapy sessions of 10 to 15 minutes.

- Specialist rehabilitation services have urgent needs of security support.

- On-site clinical psychology, neuropsychology and psychiatry services (from a consultant psychiatrist) are essential.

- Patients with multiple injuries are likely to have involvement of several orthopaedic surgeons. If consultations are delivered virtually, the effectiveness is significantly compromised.

- Follow-up appointments for neurosurgical and other specialties.

- Offer of a weekly boarding facility with patients going home at weekends – useful for vocational rehabilitation.

6.3.2 Rehabilitation Medicine Specialist Advisory Committee

An extensive response was received from a Professor and Consultant in Neurological Rehabilitation, Chair of the Rehabilitation Medicine Specialist Advisory Committee.

The response presents an extensive argument against the development of the NHSRC and the relocation of inpatient rehabilitation services from Linden Lodge, with strong concerns about the significant lack of detail contained within the proposal.

"How can anyone comment on a proposal, and how could commissioners consider what patients might benefit, in the absence of any statement about the service to be provided."

There are felt to be two fundamental problems with the proposal, specifically:

1. The isolation of the services from everything that is important – the proposal is felt to contradict the current focus of integrating rehabilitation into day-to-day practice in all hospital services, with concerns that moving rehabilitation away from other medical services would prevent integration of care / reduce the provision of holistic patient care to many patients.

   Furthermore, it is noted that services that are separated from the body of the NHS are at greater risk of developing unsafe practices or persisting with out-of-date practices.

2. A basic misunderstanding of the nature of rehabilitation - the remoteness of the location is felt to severely limit the ability and relevance of rehabilitation, with the proposal based on the assumption that patients will easily and simply, return to their home environment without further difficulties.

   Furthermore, it is noted that patients will see their family and friends less frequently and will not be exposed to any of the normal day-to-day stimuli experienced at home, fundamental parts of rehabilitation.

The response further argues that only patients who are medically stable and are unlikely to need any urgent medical diagnostic or treatment input will be able to receive treatment at the centre, and that the patients being seen will not have any special characteristics. For these reasons, it is felt unlikely that the NHSRC will attract research resources as well as any academic departments.

Furthermore, it is felt much more appropriate to have any education centre associated with an academically active and clinically active university department of rehabilitation.

Additionally, the proposed rehabilitation centre is felt to be a totally unsuitable place to base a trainee doctor in rehabilitation due to the limited rehabilitation experience as well as the limited/absent training support.

"At a time when the breadth of the curriculum has been widened markedly to meet the needs of all NHS patients, it would be inappropriate for a trainee to be based in a centre such as this which would limit experience and offer little training of value."

Further concern was raised about the financial case which relies upon the centre meeting all the local inpatient rehabilitation needs which is felt to be unrealistic and the practicality of having a three-bedded rehabilitation unit.

The response suggests that local health services would obtain much more benefit for their money by reorganising the provision of rehabilitation within existing buildings and organisations.

6.3.3 Royal College of Physicians

A response to the consultation was received from the Royal College of Physicians (RCP) on the 18th September 2020.

The response states that while the RCP support the development of the NHSRC, they do not support its development on the proposed site at Stanford Hall. They further express confusion as to whether the proposal is for a national or local NHSRC – both of which are considered problematic.

The key reasons for their objection include:

- Patients who require a Level 1 or 2 rehabilitation service need access to a range of acute medical and surgical services due to their medical instability and complex needs. Significant concern was therefore raised about the medical safety of patients if the current caseload at Linden Lodge were to be managed in this new service.

  The RCP further highlights that due to the medical instability of Covid-19 patients, as well as the fatigue associated with this condition, it is unlikely that these patients will be able to benefit from the intensive rehabilitation being offered.

- Patients would need to be transferred to and from acute NHS services which will eat into their 'rehabilitation time' and deplete their energy to engage, whilst also requiring additional staff to escort.

- If the NHSRC was a national rehabilitation centre, it would need to fulfil a role that is not provided elsewhere in the UK. However, as the purpose of rehabilitation is to get patients back to their normal lives, the RCP states that it will be extremely difficult to re-integrate patients into their own local environment from a distance.

“There could be an argument for providing short programmes of specialist inpatient rehabilitation for particular groups of patients who are poorly catered for elsewhere, but in this case the centre would need to link extremely closely with the local rehabilitation teams from all over the country to carry over the benefit once patients return to their usual environments”.

- Incorporating activities such as road safety, shopping, communicating with strangers, essential parts of the rehabilitation process, is difficult from a remote location.

- The provision of a three-bedded rehabilitation unit is not practical or possible.

- Difficulty for families, who play an integral part in the rehabilitation process, to travel to the NHSRC if they do not have a car and/or live within a reasonable distance. This was particularly a concern for mobility impaired visitors who rely on public transport.

- Suitability of the site for the placement of trainees in rehabilitation medicine given the limited nature of the caseload that could be provided.

- Providing home and work visits from such a remote site will be time-consuming and costly in terms of staff time and in provision of transport. Some patients require a phased discharge from a rehabilitation unit, which again may be difficult.

- Specialists may not be prepared/able to attend the centre on a visiting basis, and there may be little point in them doing so without access to the appropriate facilities onsite.

For these reasons, the RCP does not believe that the proposal is feasible as currently set out. Their view is that the proposed location at Stanford Hall could possibly fulfil a role as a national centre for specific cohorts of medically stable patients who are well enough to engage in and benefit from a very intensive residential rehabilitation programme.

A number of further points were put forth for consideration:

- The co-location with the DMRC will highlight the inequalities in the level of service being offered to military and NHS patients.

- NHSRC patients will only have access to the facilities at the DMRC in the evenings, by which time fatigue will make it difficult for patients to benefit, as well as falling outside the normal working hours of most NHS therapists.

- Gait analysis will be useful for a relatively small proportion of NHS patients and has proved to be more useful in a planned outpatient assessment.

- Free parking is not sufficient to compensate for the additional journey time and costs of frequent visits by car.
- Three family rooms are inadequate for 63 patients.
- Whilst broadband may help some, it does not replace actual face-to-face visits, and many patients with cognitive problems struggle to use Skype etc.

6.3.4 Paediatric Neuroscience Shared Governance Council

A response was received from the Paediatric Neuroscience Shared Governance Council on the 27th July 2020.

Support was expressed for the proposal in terms of the positive impact it will have on the outcomes for patients, recognising the deficit in rehabilitation capacity for adult services.

"This is such a positive strive for adult rehabilitation"

It was queried whether the proposal has considered accepting teenagers, due to the significant gap/grey area in provision for individuals aged 16-17 years.

6.4 Submissions from charity organisations

6.4.1 Healthwatch Lincolnshire

Healthwatch Lincolnshire submitted a response to the consultation on the 17th September 2020.

The response states that Healthwatch Lincolnshire welcome the proposal which will greatly enhance the quality of care for affected patients. However, they have three key concerns;

- Access, especially for those without cars and family support.
- Ensuring patients receive ongoing care following discharge which maintains, and builds upon, their progress achieved at the NHSRC.

  This is a particular concern in Lincolnshire, which does not have the aftercare support in place to continue the care required post discharge. It is asked whether the planning, design and delivery of the NHSRC can consider and ensure the ongoing care pathways for patients and families e.g. establishing and agreeing a suitable reablement package within a return to Lincolnshire services framework of collaboration.
- Commissioning, and how many Lincolnshire people will be able to access this centre.

The response requested information about what accessing the NHSRC would look like for Lincolnshire patients - the pathways, transport, discharge, and aftercare, as well as

the number of patients expected to be treated from Lincolnshire. Furthermore, Healthwatch Lincolnshire are keen to understand how well the Lincolnshire care system was involved and is prepared to cater for the delivery and aftercare of the centre.

6.4.2 Headway

A response from Headway – the brain injury association was received.

The response states that Headway slightly supports the proposal to create a NHSRC due to the increase in the number of rehabilitation beds that the proposal would have as well as the opportunity that would be provided for non-military brain injury survivors to access the state-of-the-art facilities at the DMRC.

However, the organisation raised concern about the transfer of the service at Linden Lodge due to the detrimental impact that the closure of Linden Lodge will have on those who are accessing the service.

Headway discussed how rehabilitation centres in hospital estates offer a smooth transition to community services, raising further concern about how the remoteness of the SHRE would provide little opportunity for brain injury survivors to re-learn lost skills such as how to use the bus or visit shops.

Their response emphasised the importance of ensuring that the new facility is accessible, particularly via public transport, due to the pivotal role that family members and carers play in a patients' rehabilitation process. Furthermore, it was suggested that the CCG should consider introducing financial support for families and carers when travelling or securing accommodation close by.

"Public transport access is of particular concern and the CCG should look to work with transport providers to secure public transport options to the new site should it go ahead. If inpatients feel lonely or isolated due to lack of visits from family or friends this could seriously impact their rehabilitation in the acute phase."

Headway requested a cost-benefit analysis to consider the establishment of the NHSRC vs upgrading existing provision across the region, and would like to ensure that if the development goes ahead that the pathways into community care are clear for patients who attend the NHSRC.

6.5 Social media

A total of 128 comments were made in response to the promotion of the consultation on social media, however only 81 of these were considered relevant. These comments were provided by 55 people.

As posts are directly identifiable, these were anonymised and summarised within the categories - positive, negative and other/neutral.

6.5.1 Positive comments

A total of 23 positive comments were recorded and covered the following themes:

- Great/brilliant idea.
- Provision of a centre of excellence with access to state-of-the-art facilities.

"It is a logical step to offer a state-of-the-art facility for rehabilitation allowing patients to benefit from a focussed rehabilitation led by experts and with extensive support services."

- Benefits of the co-location with the DMRC.

"Amazing opportunity to have funding provided for this, co-located with a world leading military rehabilitation facility which means the expertise will already be there on site. Should be a world-class service. We are very lucky to have this chance."

- A much needed facility for East Midlands patients, especially for those in Lincolnshire where there is a lack of provision.

"A state-of-the-art centre is long overdue in the East Midlands; unfortunately it cannot be on everyone's door step."

- Outdated / poor rehabilitation facilities at Linden Lodge.

"Linden Lodge at the City Hospital is outdated, it's not a very big place, the communal room is small, one of the treatment rooms doubles as the exercise room, and the equipment is outdated. My son was in there for just over 6 months."

- Other positive comment including; location accessible by public transport and willingness to travel to receive specialist care.

6.5.2 Negative comments

A total of 45 negative comments were recorded and covered the following themes:

- Remoteness of the location from Nottingham City Hospital and other hospitals, with limited public transport access.

"Virtually no public transport at all in that area."

- Difficulty for visitors, especially elderly individuals, to access the centre in terms of increased travel time and cost.

"Many can't afford to stay overnight and I'm sure the NHS won't pay for all the time, travel and accommodation expenses."

- Impact on patients of seeing their loved ones less frequently.

"Never seeing family and friends because it's too far to travel is not beneficial to patients!"

- Investment should be made into improving existing NHS facilities, not building new ones.

"The money needs to be spent on existing hospitals, not building a state-of-the-art centre. Not a good idea at all when the NHS is already struggling."

- Closure of local facilities which provide high-quality care.

“We have this already at NUH and the care there is excellent.”

- Financial modelling and sustainability of the NHSRC.

“The government is offering money to fund the building but there is no extra money for running costs. Will money be taken from other services to fund this? I worry that although it could provide an excellent service for those patients expected to make a good recovery (return to work etc.), other (perhaps older) patients might lose out.”

- Concern about privatisation of the NHSRC and the impact on the quality of care delivered.

“If it's thought to be so good and you have the funding why do you need a public consultation? Is it going to be sub-contracted to a private health business so you are covering your backs?”

- Concern that decisions have already been made and the consultation process is a tick-box exercise.

6.5.3 Other/neutral comments

A total of 13 other/neutral comments were recorded and are summarised as follows:

- Suggestion that the NHSRC is made available to major burns survivors with mental health issues.
- Discharge should be considered to convalescent homes.
- Query/speculation about the managing organisation (i.e. NHS or private).
- Query as to how staff in Nottingham, as well as other areas, feel about the location/relocation.
- Query as to whether the existing inpatient facilities in Derbyshire, Leicestershire and Loughborough will close.

6.6 Summary

Responses from stakeholders and comments provided by members of the public on social media varied in terms of their views upon the proposal.

The key advantages of the proposal are perceived as:

- Providing NHS patients’ access to a centre of excellence as well as the state-of-the-art facilities at the DMRC.
- Increasing access to specialist inpatient rehabilitation, addressing the unmet demand that exists.
- Improving patient outcomes.
- Collaboration and shared learning with the DMRC.

- Transforming how rehabilitation is delivered across the system, setting a blue print for other parts of the country.

- Opportunity for local public sector collaboration in the areas of education and research.

In contrast, strong concerns were raised about the proposal, particularly with regard to the NHS Rehabilitation Centre's location at the Stanford Hall Estate:

- The remoteness of Stanford Hall from acute medical and supporting services, resulting in a lack of continuity of care beyond the inpatient stay. Patients would need to be transferred to and from acute NHS services which will eat into their 'rehabilitation time' and deplete their energy to engage, whilst also requiring staff to escort.

- The significant number of people who would normally be able to access specialist inpatient rehabilitation ward that will be ineligible/unable to receive care at the NHSRC due to medical safety issues and/or their ability to engage in intensive rehabilitation.

- The poor accessibility of Stanford Hall, which will be difficult, time-consuming and costly for visitors and staff to access, particularly those reliant on public transport.

- Isolation of patients from their family members, friends and carers - individuals who play an integral part in the rehabilitation process.

- The distance from, and inability for patients to practice 'real world' situations e.g. crossing busy roads, getting on and off public transport - limiting the ability and relevance of rehabilitation.

- The significant lack of detail within the proposal.

- A three-bedded rehabilitation unit at Nottingham City Hospital is not practical or possible.

- Closure of a local service which provides high-quality care, with concern about the impact it will have on those currently accessing the service.

- Issues of ensuring a smooth transition from inpatient to community care and that ongoing care is able to maintain, and build upon, progress achieved at the NHSRC. This is a particular concern in Lincolnshire, which does not have the aftercare in place to continue the care required post discharge.

- Suitability of the site for the placement of trainees in rehabilitation medicine.

- Other concerns including; decisions have already been made, privatisation, financial modelling and sustainability, commissioning and equity in access for all areas.

In light of these issues and the concern that some stakeholders have about the feasibility of the proposal as it stands, a number of significant modifications to the proposal were suggested:

- Investing in the existing building/facilities

- The reorganisation of rehabilitation provision within existing buildings and organisations.

- Developing the centre as a tertiary service for specific circumstances, where there is currently inadequate and/or non-expert provision. These patients would be medically stable and wouldn't require acute medical care during their rehabilitation programme.

- Incorporation of a dynamic outpatient service.

- Opportunities for day-case/weekly boarding.

7 Conclusion

The proposal for a NHSRC provides a number of benefits not only in terms of providing NHS patients with access to a purpose-built rehabilitation facility on an existing specialist site and improving outcomes, but in transforming the delivery of neurorehabilitation across the East Midlands – addressing unmet needs, reducing demand on acute NHS services and providing opportunities for local public sector collaboration in the areas of education and research.

Survey results show that 86% support the proposal to create a NHSRC at the Stanford Hall Estate, whilst a slightly smaller proportion (69%) support the proposal to transfer the service currently provided at Linden Lodge, Nottingham City Hospital, to the NHSRC.

There are however, strong concerns about/objections to the proposal, particularly with regard to the NHS Rehabilitation Centre's location at the Stanford Hall Estate. These relate to:

- Poor accessibility of the Stanford Hall Estate – making access difficult for visitors and staff.

  Survey results indicate that 52% feel it would be very easy/easy for them to access the NHSRC, whilst 24% perceive it will be very difficult/difficult. Furthermore, 60% feel that the provision of family rooms, free parking and super-fast broadband would help to reduce the impact of increased travel time that some might face (26% stated that it would to some extent).

- Isolation of patients – contributing to feelings of low mood and/or depression.

- Difficulty for family members/carers to be involved in their relatives' rehabilitation.

- Medical safety of patients if the current caseload at Linden Lodge were to be managed in this new service.

- Options available to those who are ineligible to receive their care at the NHSRC and/or are unable to engage in intensive rehabilitation.

- Reduced continuity of care beyond inpatient stay due to the distance of the Stanford Hall Estate from acute NHS services.

- The distance from, and inability for patients to practice 'real world' situations.

- Closure of Linden Lodge, a facility considered to be more easily accessible, provide a high standard of care, benefit from the proximity to acute NHS services and provide local inpatient care.

- The impact on the transition from inpatient to community care, as well as concern as to whether the step-down care available within local communities is able to maintain, and build upon, progress achieved at the NHSRC.

- Conflict between the DMRC and the NHSRC in terms of the shared use of facilities as well as the issues of dealing with two very different population cohorts and the potential for inequalities in treatment to be highlighted.

  Survey results indicate that 65% feel it is appropriate for NHS patients to be treated on the same site as military personnel (a further 22% perceive that it is to some extent).

- Practicality of having a three-bedded rehabilitation unit at Nottingham City Hospital.

- Difficulties in the recruitment of specialist staff as well as the impact on staff at Linden Lodge.

- Suitability of the site for the placement of trainees in rehabilitation medicine.

- The impact on the surrounding area at Stanford due to the increased volume of traffic.

- Other including; financial modelling and sustainability, safety of visitors travelling and accessing the site, decisions already being made, privatisation, commissioning and equity in access for all areas.

In light of these issues and the strong concern that some stakeholders have about the feasibility of the proposal as it stands, a number of significant modifications to the proposal were put forth for consideration. These included the investment in and/or reorganisation of existing rehabilitation provision, the incorporation of a dynamic outpatient service and the development of the NHSRC as an additional facility to Linden Lodge or as a tertiary service for specific cohorts of medically stable patients.

This findings report will be provided to the NHS organisations leading the consultation, with a final decision expected to take place by the end of 2020.

8 Appendix

8.1 Engagement events – transcripts

8.1.1 Engagement Event #1; 4th August; 3-4pm

Question: In terms of the current inpatient building at Linden Lodge will neuro outpatients be expanded?

Response: We know that the building at Linden Lodge is not ideal but we are looking at how this centre would work and this is very much part of our next phase of work and we'd be keen to get peoples' views on this. How the centre, which is obviously an inpatient specialist centre, would work with the other services around i.e. the outpatients at the hospitals and also community settings as well. And also how we make sure that professionals who work in the centre are linked in with the local teams and able to share through care coordination, to make sure we get the right care plans in place for people who are leaving the centre. So I think that the outpatient part of it will be very much part of any final proposals, and we will build that in. And how much would need to happen at the City Hospital site where Linden Lodge is – how much would need to happen in other ways through community teams, we would need to work all of that through.

Question: With ongoing workforce issues within the allied health professionals (AHPs), how and when do you anticipate recruiting the specialist therapists required to support these patients?

Response 1: A huge amount of work has been undertaken to think about what the workforce requirements are, and not just based on current roles, but also thinking about what new roles we're going to need as well for this.

Response 2: It's a great question, and obviously one that's in the forefront of a lot of peoples' minds at the moment with the peoples' plan last week. So I think there are two things really to say. This does create an opportunity to support recruitment and retention within the AHP workforce. So all the work that's going on within the Chief AHP Office, and also within Health Education England, we're really going to try and take some of that forward. So rather than looking at current, rather traditional roles and ways of working, it does present an opportunity to look at the core skill sets that people need, the training and education around that, opportunities for advanced practice but also opportunities to really build in a skills escalator, so we can recruit more people into the profession in different ways. So we're exploring all of those at the moment with our academic partners and working on a workforce and a recruitment plan for exactly that reason.

Question: What banding levels do you expect to recruit? As Ministry of Defence (MOD) therapists tend to be band 6 or above. Will you expand this down to band 5 therapists?

Response: The MOD has their workforce in existence already and the MOD centre is already operational. You're right, they tend to recruit band 6 and above. We really want to see this as an opportunity to bring people through the skills escalator into profession. So we will be creating opportunities for band 5 staff and some band 4 roles in a rehabilitation instructor generic role, really to support the physical and mental aspects of rehabilitation. What's important is that we will be doing a lot of this training on the job so using apprenticeship schemes, some of which will be existing but some will have to be created in the next 2 to 3 years to fulfil that gap.

Question: The animation referred to a National Centre for training and education. Can you say more about this?

Response: We are only consulting on the NHS treatment centre because that's the money that we know we have allocated (£70million). We would then pay for the service to run, the service we are proposing about. In addition to that, the ambitions for that centre is that there is a development of research and innovation through university academic partners who have been appointed into that, and also linking in with education to really drive forward the new roles that have just been discussed, in a way that brings a centre of excellence. A longer term view would be that the learning that we get from the Stanford Hall site would be a model for how centres might be established elsewhere.

Question: Will there be an increased number of rehabilitation sessions for inpatients to support speedier discharge? Previous experience shows inconsistencies.

Response 1: The aim is that this is a much more intensive and proactive model of care, rather than, the quite patchy care that is received at the moment when people are in acute trusts.

Response 2: The model is really to bring people into a rehabilitation bed at the NHSRC as quickly as possible, as soon as they're able to do so in their journey. And to provide that intensive programme as much as they're able to cope with. But that doesn't necessarily mean 8 hours in the gym every day. The idea is that the environment will facilitate rehabilitation and independence and we'll be working through that given the feedback from the consultation, in terms of the internal layout of how the building works. The other thing is that we are developing this core generic set of rehabilitation skills alongside the work that Health Education England are doing for community rehabilitation skills, and really building on that, so that everyone has the same approach to the patient regardless of what that is.

Question: I know from the video that patient rooms are at the top of the building, so patients can see out onto the view. Will there be a lift installed to ensure safety?

Response: Yes there will probably be three lifts and we will be guided by safety and patients' ability to move, but also by fire regulations, so there are very strict rules to which we need to comply. It's quite a long building, so they will be spaced out in between. The patient rooms are at the top, on the first and second floors for exactly the reason you say. There will be therapy areas on both floors as well, but the main gym will be down on the ground floor.

Question: Do you have criteria for admission? And any thoughts on likely lengths of stay?

Response: Yes, there will be criteria for admission, in the same way we currently have criteria for the neuro rehab unit at Linden Lodge and the aim is to have assessment being done remotely via a team of people working within the rehab unit. So when people are referred to the unit they can be assessed very quickly and channelled into the rehab as appropriate. On the concept of lengths of stay it's dependent on the problem and clearly there are going to be differences depending on the reason why people are in the rehab unit, so the neuro rehab unit will I assume be having similar lengths of stay to the current rehabilitation time scales like we have at Linden Lodge. I think we're aiming for an average of 12 days for the musculoskeletal arm of rehabilitation. So again it will be very much dependent on the problem and the rehab required.

Question: Will there be accommodation for staff on site and travel to work schemes?

Response: Certainly accommodation for families planned on site, but I'm not aware of any for staff onsite. Travel to work schemes – that would be something we'd have to look at with the Trust, as to whether there was any facility for that or not.

Question: How will patients go to a step-down unit from there? Will discharge be to local multi-disciplinary teams (MDTs) for more rehab?

Response: I think it will be dependent on what's most appropriate. So yes there will certainly be a cohort of patients who do step-down to local MDT teams to continue their rehabilitation. The aim is to try and make it as seamless as we can with people gaining from the intense rehabilitation we can deliver at the centre but then get people back into their own homes or their own environments as quickly as we can.

Question: As patients may have had a prolonged length of stay in the acute ward and then a duration within a neuro rehab unit, in order to prevent bed blockages within your unit, is there the opportunity to work with other private companies to support patients in returning home? This can also support with the transition and enablement ethos.

Response: Yes we absolutely would only want people in the centre when they are really benefitting from what's required in the centre and if there are other types of care that people can have outside of the centre as part of their ongoing recovery then we would absolutely look at that. The care coordinator would help to move people on to their next destination. So that may well be that there's a specific arrangement for those individuals depending on what their needs are, which could be with a private company. There would be, and we would often do that where people have got ongoing continuing healthcare needs or other needs. This has got to work as a whole network of services. It won't work if it's just on its own and isolated without proper ongoing plans for peoples' recovery.

8.1.2 Engagement Event #2; 10th August; 2.30-3.30pm

Question: I have multiple sclerosis and have benefitted from being an inpatient at Linden Lodge. I have many concerns about losing this facility, at the moment there are I believe 24 neuro rehab beds, can you guarantee that there will still be that many in the new facility? I am concerned that because we cannot be "cured" we will be put at the back of the line for beds. It is only due to me being at Linden Lodge that I can walk again. What will happen to staff that do not want to move? Will their expertise be lost to patients like myself? Also the distance from Nottingham is worrying as I know too well you need support from family and friends, I had a very frightened 9 year old who fortunately was able to visit me every day which helped both myself and him. If it was moved he would not have been able to visit as often, causing anxiety not just to me but him too, when you have lost the ability to move and been given a diagnosis such as MS, relationships are vital in your recovery and acceptance.

Response: It's a really good question and sets out very well a lot of the points that we have given some consideration to and will continue to need to consider. So the numbers of beds in the new unit, create an additional 40 beds, and very much the model that we are putting forward does include the current neuro-rehabilitation levels of beds. So for anyone who currently needs – we don't think there will be a reduction in any neuro rehab bed capacity and we will make absolutely sure that people aren't left without care.

What we're also doing – and we're very keen to hear from people who do use the service – is thinking about how those services can best work with local community services. Partly for the reasons that have been described. We won't just commission the centre on its own, we would think about all of the local support that patients would need. And it would absolutely include all people who could benefit from the rehabilitation - so not just injuries and traffic accidents etc., if people with long term

conditions, such as MS, have got that ability and the willingness and drive to do the rehabilitation, and get back to a greater level of independence in various points in the disease, then they absolutely would remain eligible for the new service. The preference would be people who can benefit from rehabilitation, not putting at disadvantage people who have got long term conditions.

I think for staff not wanting to move, we will look at what redeployment opportunities there are within the hospital or surrounds, we would absolutely want to retain those skills if at all possible. We would work very flexibly around that. I think the point you make about visiting and isolation from families, especially with a young child as you've described – we're very sensitive around that. So I think some of that would be virtual access. There would be free virtual access and use of WIFI in the facility. And also the ability to stay over as well. So again I think as we go through the consultation we'd want any suggestions around how that could work best, because it's in everybody's best interests if people can maintain their networks.

Question: Can you elaborate on how the proposal will affect Lincolnshire? How will people in Lincolnshire gain access to the service?

Response: We are working with Lincolnshire CCG on what the opportunities are for this service as it's a regional one. The business case recognises that with NUH being a regional major trauma centre a number of patients will go into NUH whether they are Lincolnshire, Leicestershire etc., and they will have the opportunity to transfer directly to the rehab centre. Alongside that, it's what additional capacity would be beneficial to Lincolnshire for the patients that are also going through the Lincolnshire hospitals. We've presented to the Lincolnshire Health Scrutiny Committee and their questions have been taken into consideration in relation to the consultation as well. So there's been considerable input from Lincolnshire.

Question: In Lincolnshire how will you ensure patients discharged back to the county are ensured an unbroken service and any ongoing services required, including social care, will be available?

Response: The intention is that there will be a MDT who take the referrals and assess the referrals in terms of arranging admission to the unit. So Lincolnshire patients would be part of that system, as are Nottinghamshire patients or Derbyshire patients for example. The teams would include care coordinators who will work with the local areas and the patients and their families, to make sure that we plan the discharges back and do that right through the period of admission as well.

Question: Is the rehab centre for long term or short term care, are you expecting to discharge them to the community and will the rehab centre provide support in the community?

Response: The rehabilitation centre is going to be trying to deliver the most appropriate care for people, so whether it's long term or short term, if it's most appropriate to be delivered in that setting, that's the plan that it will achieve. The aim is that the rehabilitation pathway – the process the patient goes through - will be continuous with them going back into the community. The services that are already in the community –

that already provide those community rehabilitation services – will still exist. There will be a process were patients are handed over from the intense inpatient area into the community area so people can be rehabilitated closer to home and in their own home as appropriate.

Question: How long is the lease on the site from the Grosvenor Estate?

Response: The lease on the Grosvenor Estate is currently set to be around 65 years and that's basically in the capital business case, and we just have to go through a process of calculating the building depreciation life and it marries up to that.

Comment: There are very little current services for inpatient brain injury rehabilitation in Lincolnshire now. Many patients have to go out of County for Rehab anyway.

Response: That is certainly the case, and that's part of the discussions with the Lincolnshire commissioners as well. The discussions around how Lincolnshire patients might use the services at Stanford Hall are ongoing. But I think it would be obviously recognised and accepted that many people already do go out of Lincolnshire, so that would be part of the thinking around using that site. I wouldn't say it's no change, because it's not. It depends where you live in Lincolnshire and where you would have gone previously, but the notion of patients travelling for that service wouldn't be a new thing.

Question: Will patients from Northamptonshire - which is also part of the East Midlands, have access to these services. Are the Northamptonshire CCGs involved in this?

Response 1: The services are for the East Midlands trauma network, which doesn't include Northamptonshire. There were earlier discussions with them, and they didn't feel their patient flow would be towards a rehab centre. However, as mentioned for patients the flow through is NUH, so there may be some patients who are from Northamptonshire and who have been in NUH and it's appropriate for them to transfer to the rehab centre. So if that capacity is available it may be that they do transfer to the centre. But the key point is that the centre is for the East Midlands trauma network.

Response 2: It was just a geographical boundary that we offered to them, but they declined to be involved. Everybody from that area tends to go south towards Coventry to access their acute and rehabilitation services at the moment and they didn't feel that was necessary to change.

Question: Are you clear on the extent of community rehab capacity in the counties who will refer patients? Do you have data that shows that capacity meets current demand, or do you already have community rehab capacity deficit which an increase in beds may exacerbate i.e. lead to more pressure on community rehab?

Response 1: My perception is we need more rehabilitation services across the board. We'd benefit from more in the community, we'd benefit from more in secondary care, and we'd benefit from higher level – at the rehab centre. So my belief is if we provide more rehabilitation beds that should take some of the load that currently is in stretched

services in the community. The plan is that it would actually help address some of the need as opposed to add to the requirement.

Response 2: We have undertaken some workshops with community provider colleagues as well, to test out the thinking. We will continue to build up that work as we work through the proposals in more detail. It’s still work ongoing and it’s an area that is important.

Question: I currently attend yearly appointments with my rehab consultant at Nottingham city hospital, would you envisage these appointments be moved to the new facility?

Response: The short answer is I don’t think they’ll move. I think most of the out-patient service will remain in Nottinghamshire, within the outpatient service. There will be opportunities for going out to the rehab service but I suspect most of it will happen in Nottingham.

Question: Will there be day care opportunities at the facility?

Response 1: At the moment the main emphasis has been on the inpatient facilities.

Response 2: We have focussed entirely on inpatient facilities for patients who are currently in hospital beds who need that level of care. There are lots of different levels of rehabilitation and at the moment it is recognised that outpatient and community services are probably best served closer to home. So we don’t have any plans for that as it currently stands.

Question: Will there be dialysis facilities for those needing ongoing haemodialysis, like those provided at Lings Bar?

Response: Really good question and it’s something that we are addressing even at Linden Lodge at the moment with our current service being at the City Hospital. What we’re actually trying to look to do, as dialysis takes up so much time, is one of two options which we haven’t concluded – either yes having a dialysis facility there, or having more of an outreach service for patients who require that regular dialysis at the City campus. Any views on that would be very welcome.

Question: What about outpatient services for Lincolnshire patients?

Response 1: This is something we would need to work through with the local teams and the care coordinators would need to continue to work with the local teams. As far as possible we would keep outpatients and community services as close to where people live.

Response 2: One thing that we’ve really learnt from Covid is the ability to do quite a lot of consultations via video, and certainly we’ve changed a lot of our practice recently. So what we’re also looking at is where we do that from, and if it’s a virtual consultation and the multi-disciplinary team is at the NHSRC for example, then there might be an opportunity around that. But we haven’t made any decisions about that. It’s important to recognise what we have learnt through the last three to four months as well.

Question: Will medical/nursing/physio/OT etc. students be placed at the new centre?

Response: The ambition around the new centre is to be the national rehab centre and that includes the national training and education centre for rehabilitation. So yes absolutely there will be placement opportunities for students there and we hope from a number of disciplines – medical, nursing, physio, OT, and others including healthcare, scientists, pharmacists etc. as well. I think one of the ways that people are changing to support the Health Education England programme and the Five Year Forward View is to try and offer some of those student placements and clinical placements virtually and in a simulated way rather than face to face. But we can certainly help with all of those.

Question: In which case, will there be accommodation available locally for students?

Response: That will work, I think, in the way it does now. So there won't be accommodation on site as such, but there will be access to that nearby if students need that.

Question: Is there a timescale for developing the national offer?

Response 1: The current consultation is very much around the clinical facility, at the same time there is a lot of work for developing how we work with academic partners around education, but also the research as well. As we said at the beginning the vision is that this then becomes a model that is rolled out more nationally.

Response 2: We've developed an academic consortium with 26 universities, the direct partners of which are the University of Nottingham and Loughborough University, to develop that national offer. That focuses on training and education, but also around research and innovation, so that we attract skills and expertise into the region and really maximise the opportunity that we've got. The overall timescale on that, after the consultation and the next part of the process, we're still looking at another probably 18 months' worth of business case process and then a two year build. That's not to say that some of that activity, particularly the academic activity, will be able to start before then, and that's very much what we're hoping to deliver.

Question: Will there be medical cover 24/7 please? Currently there is neuro physio support from Linden Lodge on the acute neuro wards, and Reablement/outpatient ongoing support which is planned seamlessly on site. Will this new development fracture the neuro journey of complex patients?

Response 1: Yes, recognising the fact that we want to bring people through into the centre as early as possible. There will be 24/7 medical cover there – that's very, very important. For MSK/orthopaedic patients there will also be the ability to go back to the site for any reconstructive surgery, and that will all be in a planned way.

Response 2: The ongoing seamless approach to this is something we want to continue on at the NHSRC. There certainly will still be the acute neuro physios on the acute wards but also we're planning a rotational aspect of these staff, so that we spread that expertise across the pathway, but also learn from them and share that learning further down the pathway as well. There's definitely work underway already to look at the whole pathway not just the NHSRC, the neuro reablement team that you talk about will

still exist and it will continue to run out of the NHSRC, so that we can continue that seamless work as patients progress through to discharge.

Question: I have spoken with therapists who are concerned about rotation due to childcare, length of shifts and travelling time. Can they refuse to rotate?

Response: Yes, rotation offers an opportunity to specialise in certain clinical areas, at some point in everybody's career most people rotate. There will be a combination however of static posts in the NHSRC and rotational posts, so people do have that choice. So yes is the short answer. There are also static posts in the acute trust as well. We hope that people will see this as an opportunity rather than anything else, and an opportunity to rotate not just through the NHSRC and the acute trust but also into community services as well.

8.1.3 Engagement Event #3; 19th August 2020; 6-7pm

Question: Which organisation will be responsible for the management of the Rehab Centre?

Response: What we anticipate is that this centre will have to work really well with community services, mental health services and other services, so it will be part of a pathway; we envisage that the care pathways will be managed by a range of NHS organisations. There will be one that takes the lead or provides most of the care. We believe there needs to be some sort of partnership and integration where people live as well. So we think it will be an NHS service with NHS organisations involving more than one organisation to have the correct input particularly around mental health. We can't finalise that at this stage, we have to take all the comments from the consultation, go through the process I have described with the independent analysis and then we confirm that at a later date. So that is not something we can categorically confirm at the moment but we think it will be an NHS body with input from a whole range of health professionals across.

Question: What additional facilities/equipment will available through the DMRC?

Response: The DMRC has a large range of different therapy gyms, it's got a very impressive hydrotherapy suite with several pools and it's got some hi-tech equipment that we don't have in the NHS such as the CAREN equipment, which was shown on the slides. These are things where you can use computer feedback to try and help people regain balance and start to learn movement patterns so there is quite a lot of significant amount of opportunity within the DMRC.

Question: What will be the benefits of the new service compared with what's available now?

Response 1: I think the key thing is that it is all in one place in a facility that is designed specifically for rehabilitation with all the equipment and expertise in one place. What people say to us now is that sometimes they have to travel in between places as all the care they need is not necessarily available in one place. Also, because there will be individual care plans, agreed with the individuals, with a whole range of professionals, it's probably a more intensive, more rapid sort of programme of rehabilitation. We do believe from the international evidence that gives people a better chance of a better recovery and getting back to the normal activities of life as far as possible really. It's about reaching that absolute potential.

Response 2: We have noticed with the creation of a major trauma centre and specialising things in one area and getting a lot of expertise, the initial care has

improved dramatically. I guess what we are hoping is that by getting our patients to a specialised rehab place, those kind of benefits - from dedicated staff working together, working with the defence union next door – will really accelerate their recovery after resuscitation and surgery so the whole journey is just as good as it possibly can be and there is no wasted time and there is no loss of condition so that the patients are just flying through their rehab. I think that this will deliver that for us.

Question: I am concerned that, as there is no extra money to run the new centre, patients with less intensive rehabilitation needs will experience a worse service as a result of money being transferred to this more expensive, intensive service.

Response 1: The way that the business case is constructed, is that in order not to have a negative impact on other services, we are transferring the resources from Linden Lodge in that neurological rehab facility and putting those together with other resources which we don't think we are using to the maximum effect at the moment. We know that in NUH, at any one time, there are people on the wards who really are waiting for their rehabilitation. They are in hospital and that obviously has a resource implication but they are not getting the type of care and rapid forward movement that has been described. The resources for this would be taken from Linden Lodge primarily as well as the money that we are currently spending in not such a good way for people who are in hospital waiting for their rehabilitation journey. It's a combination of both of those two things and some other areas as well. For example, continuing healthcare, where we believe there will be some benefits to people's long term progress and level of dependence. We're not actually taking money from other types of rehabilitation in order to fund this new centre; this was quite a deliberate thing because we know that we can't negatively impact the other areas in order to accommodate this.

Response 2: At the major trauma centre, we see patients who need rehabilitation and can't access it; essentially money is being spent ineffectively - keeping them in an acute hospital. The idea of the business case is to gain the efficiency of them moving to the rehabilitation centre rather than take any finance away from other areas of rehabilitation that we are providing to patients with less acute requirements. Hopefully we will actually be able to spend NHS money more wisely and appropriately than we are currently able to.

Question: Will there be fewer beds for people from Nottingham and Nottinghamshire?

Response: We don't believe so, because as we have just described, the way we have worked out the resources for the running of the centre is on the number of beds in Linden Lodge, which would directly transfer, plus the number of people who are currently sitting on the wards waiting for this type of care to move. We believe there are some people from outlying areas as well, but often they will already be in NUH because of the major trauma centre, so we don't believe there will be fewer beds for people in Nottingham and Nottinghamshire based on how those proposals have been built up.

Question: Last year it was in the news that the MOD would only pay for serving personnel, not veterans. Veterans would need to be paid for by the NHS. What is the situation?

Response: That is slightly outside of this facility. The normal funding for NHS care for veterans would continue should they need specialist rehabilitation as it does in other walks of life. My stance, the CCG commissions care for veterans. I believe that is the correct position.

Question: How do the staff at City Hospital feel about transferring to Stanford Hall? Will you be able to recruit the skilled staff to work there?

Response: There has been a lot of engagement with staff at Linden Lodge and showing them what the opportunities are. Like for any move some people are slightly concerned but we are engaging with them on a regular basis, trying to give them enough knowledge to allay those views and to see the tremendous opportunity. We don't see that we will have a huge difficulty in recruiting additional staff, we already have the skilled staff at Linden Lodge to work there and I think that's been shown in the recruitment that the military did at Stanford Hall as well. This will be a world leading rehabilitation centre and anybody with interest in rehabilitating this group of patients will be very keen to work there so we don't feel that we would have difficulty in recruiting and we are working closely with our Linden Lodge colleagues to make sure they are informed every step of the way.

Question: There will be no extra money for running this service. Where will the savings be made to fund the running costs?

Response: I think we may have covered this, so this is the transfer of the cost of running Linden Lodge and the cost of the patients in NUH, who are waiting for rehabilitation services, so that funding of running those beds will transfer effectively.

Question: Could you please explain what the impact/changes for patients in Lincolnshire requiring inpatient neuro-rehabilitation would be?

Response 1: Lincolnshire has a 2B unit already and a 2A unit neuro rehab unit so this would provide some additional neuro rehab capacity to that. Then there's also the MSK beds that Lincoln clinicians would be able to refer into or that people would transfer from NUH, so it would be some additional rehabilitation capacity for Lincoln.

Response 2: I'm the clinical case manager at the NHSRC. In addition to the Lincolnshire beds that already exist, we know that there big gaps in Lincolnshire, not only for inpatient neuro rehab but also for outpatient care. Providing the additional beds at the NHSRC would give patients the choice that if they don't want to wait in an acute bed, for often 3 or 4 weeks, they could transfer to the NHSRC and receive their rehab in a much timelier manner but also have access to the additional resources that are available there. We are working quite closely with Lincolnshire colleagues to perhaps develop services in the future where we do joint clinics and things like that so hopefully this should improve services for the entire region.

Response 3: A lot of the patients in the major trauma centre are from around the region, although this centre will be situated in Nottinghamshire itself, the patients that we deal with coming to the major trauma centre are from around the whole of the East Midlands and so I think there will be direct benefit for all patients from the whole region not just local patients. This should definitely be considered as a region wide centre despite its location.

Question: Will the MoD facilities be freely available to NHS patients or will they be hugely restricted in terms of access and staff availability? Also thinking of infection control.

Response 1: We've got an agreement with the MoD for the facilities to be available, clearly we will need to arrange timing so it won't be anytime day or night but there will be sessions where NHS patients have access to CAREN, the gym and the hydro therapy pools and equally it is mentioned that there is access to the entire estate for NHS patients as well. So there will be a time table that is set out and obviously with COVID, that will be taken into account when the timetable is drawn up.

Response 2: We are in the process of many discussions with the DMRC, talking about the facilities and they have shown an open appreciation of what they might be able to

help us with. It’s also important to realise about the staffing - that the use of those facilities in the gyms, hydro therapy pools will be staff by the NHS staff from the NHSRC, not the military staff.

Question: How will the service compare with, and learn from, equivalents in other countries?

Response 1: We are sending a few of our team members to state of the art facilities around the world and we have taken a lot of inspiration from some amazing rehab centres in North America but also in Switzerland and Sweden. There is a real opportunity here to give us that state of the art rehab centre that the entire county is lacking and we’ve got the opportunity here to be a leader, to put the region on the map, to really highlight the fact that we can learn from all these other areas and different countries to make sure that we get the service right. So there’s lots of involvement with counterparts internationally to make sure that we get the service right but also making sure we get the service right for our cohort of patients so that’s certainly something that’s been taken into consideration.

Response 2: The UK does compare rather poorly with many other western countries, particularly in Europe and also North America when you compare the number of patients who can return to work and we believe this is a very powerful reason that we need to have increased resources within the rehabilitation - there is a very powerful argument for the NHSRC centre.

Question: It frees up the beds at the current facility which is excellent, however does this cause the commissioner an issue if these beds are then filled by other patients? Great for us patients but are there knock on effects to affordability for other NHS services.

Response: It’s a very good question and it something that as we have developed the proposals that we have had to think very carefully about. The funding that has been released from the government or is going to be released from the government to build the facility, is on the basis that we are able to pay for the running of it within an affordable level so, as described in the business case, we do need to make sure that we transfer those resources across. That’s a condition on the release of the money to build the facility so we all need to make sure that we work together to ensure that is the case. We do have to commission a range of rehabilitation services as well and other services, we have to make sure there is a good spread of services in line within what the NHS needs to offer, so I think as was mentioned earlier, we do need to use the money as wisely as we possibly can.

Question: Will there be patients who are eligible for Linden Lodge now who will not be eligible for the new rehab centre?

Response 1: No, absolutely not. We were doing a lot of work on our current eligibility criteria for Linden Lodge and actually we’re realising that more and more patients actually need access to that service. So there certainly won’t be any patients who are eligible now that won’t be eligible. We will be transferring the current Linden Lodge service as it is over to the NHSRC, so that will remain. If anything, we will be improving the access to rehab for many patients who don’t get rehab at present, so we envisage there will be more access to rehab not less.

Response 2: In the business case it has been identified that there is probably the equivalent of three beds of activity that currently go through the Linden Lodge, that wouldn’t be fit for the rehab centre. What we have included in the business case is maintaining the capacity at NUH for these patients. There are some patients that currently go to Linden Lodge that won’t be able to go to the NHSRC according to the

audit that has been carried out. We have factored that in to the business case and that is included in the financial model and all the elements around that.

Response 3: When we have looked at those patients, three patients were identified as not being eligible for the NHSRC. However, we have actually determined that aren't suitable for Linden Lodge either but for whatever reason and whatever pathway, they have ended up there but actually, that just means we could manage their discharge and facilitate that discharge in the community. They might not be in the right service and we can signpost them to the right service. There will always be an element that we don't get it right 100% of the time but it does mean that we can just facilitate their transition the same way as we would do for any of the other patients.

Question: Will the service take privately funded patients?

Response: Our business case and our proposals are purely for NHS patients.

Question: Will the centre be Level 1, 2a, 2b or mixed?

Response 1: This will not be a level 1 service but there is a huge overlap in 2a and 2b and the NHSRC will be expected to take patients that are currently categorised, some as 2a and some from 2b. There is actually a national consideration of trying to combine 2a and 2b because the categorisations are not working very accurately in the sense that they are currently being used.

Response 2: There is also the consideration of how the service is commissioned, so there are specifically 2a units so 1 and 2a units that are commissioned by NHS England. The thing that we are working with NHS England on overall is what we do have within the East Midlands for level 1, 2a and 2b and how the rehab centre can support that, it would predominantly be 2b.

Question: Will there be neurobehavioral/neuropsychiatric beds available? Will any of these be managed under the MHA?

Response: This a cohort of patients that we're currently doing some work on at the minute - to actually find out where best meets their needs. As we know, some neuro behavioural patients often have lots of complex needs – some of these can be addressed at the NHSRC but some can't. We do have in our region, Lemington and some others, which is purely for neuro behavioural patients or neuro psychiatric patients, so we are looking at those pathways to better understand where these patients would most appropriately be looked after. We certainly haven't ruled it out, that being the NHSRC. We will have neuro psychiatry and neuro psychology access at the NHSRC so this is certainly something that we can look into and work is being done at the moment to look into that.

Question: When will the final decision be made?

Response: We anticipate that it will be towards the end of the year, sort of early December time.

Comment: I hear what you say about the funding but it really sounds impossible to run such an enhanced service on the same money. I can't see how you can save money by freeing up beds in NUH as they will of course be used by other patients.

Response: We will need to transfer the resources across to the centre. Every year we always do quite a detailed exercise around how best to spend the NHS pound that we've got to treat a whole range of conditions. The other point to make is obviously this is a new service and we will develop the evidence over time, but based on international

evidence and we are doing some further analysis around this, when we move towards developing the final business case is what possible savings there might be elsewhere in the system. I did mention earlier on that we believe that the enhanced recovery people will have with a shorter perhaps more intensive rehabilitation, will save us money further down the line for people who get a higher level of functioning back as a result of the rehabilitation and therefore they need less healthcare later down the track. What we would like to do is have a look at this and try and understand it across not just NHS spend, but also whether it helps people get back to work and the benefits from that point of view in terms of benefits and savings across a whole range of areas.

8.1 Demographics of survey respondents

***Table**: Age (n=714)*

Response	%
18-24	2%
25-34	16%
35-44	22%
45-54	27%
55-64	19%
65-74	11%
75+	4%

***Table**: Gender (n=703)*

Response	%
Woman	78%
Man	21%
Other	<1%

***Table**: Gender identity match sex registered at birth (n=704)*

Response	%
Yes	100%

***Table**: Pregnant or had child in the last year (n=699)*

Response	%
Yes	2%
No	98%

***Table**: Marital status (n=678)*

Response	%
Married	64%
Cohabiting	14%
Single	11%
Divorced or civil partnership dissolved	5%
Widowed or a surviving partner from a civil partnership	3%
Separated	1%
In a civil partnership	1%

***Table**: Disability, long-term illness or health condition (n=713)*

Response	%
No known impairment, health condition or learning difference	69%
A long standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease or epilepsy	8%
A mental health difficulty, such as depression, schizophrenia or anxiety disorder	5%
A physical impairment or mobility issues, such as difficulty using your arms or using wheelchair or crutches	8%
A social/communication impairment such as speech and language impairment or Asperger's syndrome/other autistic spectrum disorder	1%
A specific learning difficulty such as dyslexia, dyspraxia or	2%

AD(H)D	
Blind or have a visual impairment uncorrected by glasses	1%
Deaf or have a hearing impairment	4%
An impairment, health condition or learning difference that is not listed	5%

***Table**: Unpaid carer of a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction (n=691)*

Response	%
Yes	15%
No	85%

***Table**: Race / ethnicity (n=683)*

Response	%
White	94%
White - Irish	2%
Asian/British Asian: Indian	1%
Asian/British Asian: Pakistani	1%
Asian/British Asian: Bangladeshi	<1%
Black/British Black: African	<1%
Mixed – White & Asian	<1%
Mixed – White & Black Caribbean	<1%
Other Asian background	<1%
Other mixed background	<1%
Chinese	<1%
Mixed – White & Black African	<1%

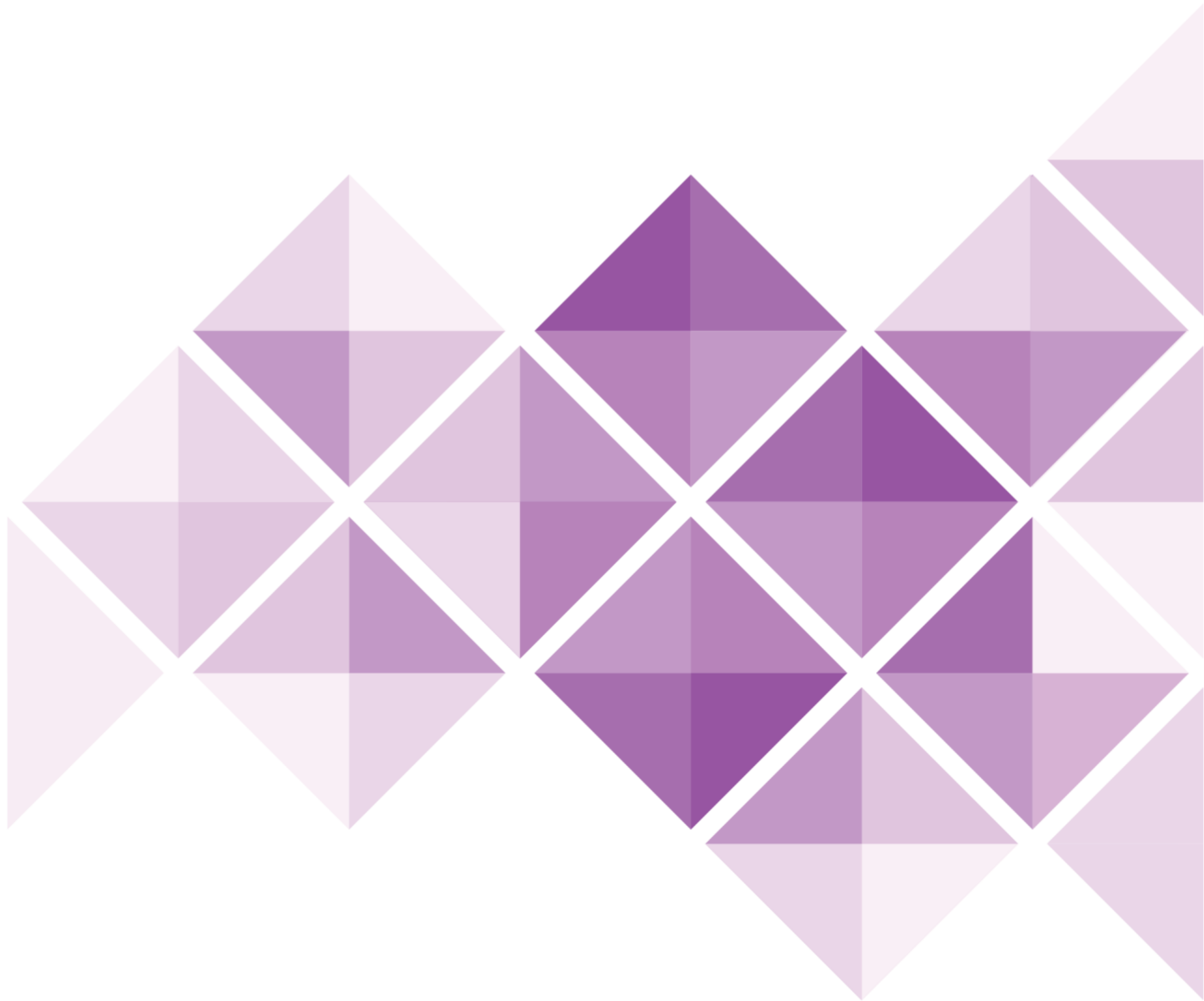
***Table**: Sexual orientation (n=638)*

Response	%
Heterosexual or straight	93%
Asexual	3%
Bisexual	2%
Gay woman / lesbian	1%
Gay man	1%
Other	<1%
Queer	<1%

***Table**: Religion (n=664)*

Response	%
No religion	47%
Christian	40%
Christian – Roman Catholic	5%
Christian – Other denomination	3%
Other	1%
Christian – Church of Scotland	1%
Spiritual	1%
Hindu	1%
Buddhist	1%
Muslim	<1%
Christian – Church of Ireland	<1%

Christian – Methodist Church in Ireland	<1%
Christian – Presbyterian Church in Ireland	<1%



healthwatch
Nottingham & Nottinghamshire

NHS Rehabilitation Centre Report

September 2020

Commissioned by

Nottingham and Nottinghamshire Clinical Commissioning Group

‘I don't want to go onto a waiting list for getting help. When people need services they have already been through enough trauma and they need help now!’

Comment from respondent

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Who are Healthwatch Nottingham & Nottinghamshire?

Healthwatch Nottingham & Nottinghamshire is an independent organisation that helps people get the best from local health and social care services. We want to hear about your experiences, whether they are good or bad.

We use this information to bring about changes in how services are designed and delivered, to make them better for everyone.

Why is it important?

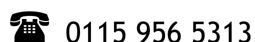
You are the expert on the services you use, so you know what is done well and what could be improved.

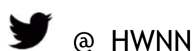
Your comments allow us to create an overall picture of the quality of local services. We then work with the people who design and deliver health and social care services to help improve them.

How do I get involved?

We want to hear your comments about services such as GPs, home care, hospitals, children and young people's services, pharmacies and care homes.

You can have your say by:





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We produce regular newsletters that feature important national health and social care news, as well as updates on local services, consultations and events.
You can sign up to our mailing list by contacting the office by phone, email or by visiting our website.

Executive summary

In 2020 Healthwatch Nottingham and Nottinghamshire were commissioned by Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) to find out from people with protected characteristics and health inclusion groups what their views were about moving the current rehabilitation services based at Linden Lodge, City Hospital, Nottingham to The NHS Rehabilitation Centre, Stanford Hall Estate, Loughborough.

Ninety-one telephone interviews were carried out over a seven week period using a survey designed in conjunction with the CCG. The target population for this survey was people of different ages, abilities, ethnicities, religions, sex and sexuality, people living in poverty, who were homeless, unemployed and at risk of poor health outcomes.

The interviews aimed to find out:

- what specific needs people have that NHS England should consider in planning rehabilitation services
- the barriers people face in being able to access and benefit from rehabilitation services

Specific needs to consider

People expressed a wide range of needs most significantly about things that would maintain and improve their mental wellbeing. These are detailed below:

- Two thirds felt there would be a need for mental as well as physical rehabilitation and 15 require ongoing support with their existing mental health condition.
- Parents with babies want to be able to share a room with them and assistance provided if required. For people who have other dependents e.g. older parents, on site social care advice would be helpful.
- Over half of the people would like their own room, over one third their own bathroom and nearly a quarter would like a TV. Sharing a room for company was important to 17 people as was a homely space for 14. Being able to accommodate visiting children and family in their room was also an important consideration for some. More than half would like some sort of privacy; staff knocking before entry was requested by 17 people, and a confidential place to discuss their health was also needed.
- More than half have their own phone or laptop and would like to use this to communicate with family and friends.
- Accessing outside space was a necessity for over two thirds of people for fresh air, exercise, and to maintain good mental health. In addition over one fifth of people would like to be able to go off site, with assistance if necessary.
- While over a half of people had no special dietary requirements the rest would like a choice at each mealtime, a balanced diet and vegan, vegetarian, diabetic etc. options.
- Two thirds of people felt a ‘neutral’ religious space onsite was required, however for 12 having someone to talk to was more important that the space itself.
- Over a quarter of people would like access to a GP/Medical Centre onsite; those with existing conditions require prescriptions and medication to be continued along with access to their existing specialist.
- Nearly half described the necessity for public transport for themselves, family and friends to get to The Centre.
- More than one third of people require occasional accommodation for family and friends with one quarter requesting reasonable hostel rates.
- Two thirds of people would like an on-site shop. Newspapers, magazine and books were the first preference followed by snacks, sweets, crisps and toiletries. A café, chemist, cash machine and restaurant were also mentioned.

Barriers

- Concerns were raised about the different culture between civilians and military, the increased security levels, interacting with military patients who have PTSD, and regimented routines.
- Access to a landline preferably in their own room was important to nearly a third of people. Access to Wi-Fi was a necessity for over a third of people and, if charged for, would be prohibitive to eight.
- Fourteen people said that unless the cost of public transport was reasonable it would be prohibitive for them. Over a third would like free or cheap car parking.

In order to address these specific needs and barriers to access, it is recommended that the CCG takes the following actions:

Specific needs to consider

- Continue to provide mental health support for people with existing conditions from the service they are in contact with. Where new services are provided, ensure that this is tailored to the needs of the individual.
- Where new mental health conditions arise, ensure that people are able to talk to a professional about this.
- Ensure there is provision for parents to care for babies on site. Provide social care guidance to support and care for young children and adults in order to reduce the stress on the patient.
- Offer a variety of accommodation options and allow patients to give their preference to assist their recovery.
- Allow patients to use their own phone/laptop while at The Centre with free Wi-Fi access for all patients, and landline in their own room on request. Consider individual needs on a case-by-case basis for example voice recognition and 24-hour access.
- Provide easy independent access to outside space with a large range of facilities to meet different people's needs.
- Ensure that civilians and military patients are aware they will be sharing certain spaces at The Centre. Staff to consider the different needs and culture of military and civilian patients.
- Provide a range of choices at mealtimes including healthy balanced diets and occasional 'treats'. Ensure that specific dietary needs are met for individuals and that people have the implements to allow them to eat independently.
- Provide at least a multi-faith room to allow people to practise their religion as well as facilitating access to visiting faith leaders. Consider whether a separate room would be required for certain faiths.
- Address people's privacy needs on an individual basis and ensure there are private places to speak to health professionals and relatives if requested.
- Ensure swift transfer of medical files and continue to provide repeat prescriptions and GP check-ups as required where possible on site or with transport provided for specialist services. Consider people who require other ongoing treatment, either providing transport to their facility or bringing in medical specialists.
- Provide public transport to the door of The Centre, preferably by a shuttle service from the train and bus stations for patients, family and friends. Provide free parking for patients.
- Provide onsite accommodation for family and friends at reasonable rates.
- At minimum a hospital shop with basic items is required. A café / restaurant is also important for both patients and visitors.

Barriers

- Provide information about The Centre to patients to address concerns about being on the same site as military personnel.
- Ensure that all patients have affordable ways to communicate with their family and friends.
- Ensure that affordable public transport to The Centre is available.

Introduction

In December 2019 Healthwatch Nottingham and Nottinghamshire (HWNN) was commissioned by Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) to carry out a part of the formal consultation on the development of inpatient rehabilitation services (following serious illness or injury) at the NHS Rehabilitation Centre (NHS RC). The proposal is that the NHS RC would be developed on the Stanford Hall Rehabilitation Estate, Loughborough which hosts the Defence Medical Rehabilitation Centre (DMRC). This is a 360-acre countryside estate providing high quality clinical rehabilitation services to defence personnel.

The aims of this project were to:

- Find out what specific needs people have that NHS England should consider in planning rehabilitation services
- Find out what are the barriers people face in being able to access and benefit from rehabilitation services
- Focus on the views of people who have protected characteristics and are in health inclusion groups

Background

The population of the East Midlands is 4.6 million and there are 79 rehabilitation beds – a shortfall of 191 beds for the region (according to the British Society of Rehabilitation Medicine). The East Midlands trauma region treats over 1,700 major trauma patients per year (approximately 15,000 hospital bed-days), most of whom will require some form of rehabilitation.

The proposed NHS RC facility would contain 63 beds, comprising 40 neurological rehabilitation beds, 19 complex MSK beds and four traumatic amputee rehabilitation beds treating 796 patients per year. Part of the proposal is that Linden Lodge at Nottingham City Hospital will close. This is because the estate is no longer at the required standard and there is no space to expand. Twenty-one of the current 24 beds at Linden Lodge would be moved to the NHS RC, with three rehabilitation beds moving to another location within the Nottingham City Hospital campus. Eighteen beds for musculoskeletal (MSK) rehabilitation may also be relocated to the NHS RC.

Patients would be referred to the service based on clinical need. These will include the most seriously injured patients from accidents including sporting accidents, road traffic accidents, farming accidents and urban crime, neurological patients, complex MSK, traumatic amputees, incomplete spinal cord injury and severely deconditioned patients. (A deconditioned patient is one who has potentially reversible changes in body systems brought about by physical inactivity and disuse).

Our approach

Between January and June 2020 HWNN worked with the NHS RC team to develop the survey questions, pilot them and write the information leaflet and A5 promotional flyer.

An orientation workshop was held on 22nd July 2020 attended by two Healthwatch staff and three Healthwatch volunteers. The aims of this workshop were to fully understand the rationale for the project, refresh participants' knowledge of how to carry out 1-to-1 interviews, familiarise staff and volunteers with the materials and resources to be used, and to practice asking and answering the survey questions.

HWNN carried out a mapping exercise to identify groups across Nottinghamshire County and Nottingham City to ensure a demographic and geographical spread of groups. HWNN targeted a diverse range of community and self-help groups focusing on:

Protected Characteristics

- Age
- Disability
- Parents with young children
- Ethnicity
- Religion or belief
- Sex
- Sexual orientation

Inclusion Health Groups

- People who are homeless
- People who live in poverty
- People who are long-term unemployed
- People in stigmatized occupations
- Other groups at risk of poor health outcomes

Demographics of participants

Between 30th July 2020 and 11th September 2020 a total of 91 surveys were carried out by telephone. Interviewees were from the following cohorts:

Cohort	Number
Female	48
Male	43
At risk of poor health outcomes/long term health condition	35
Have a physical disability	19
Have a learning disability	12
Have an existing mental health condition	15
Aged 25 years and younger	23
Aged 75 and over	15
Christian	42
Other religion, Buddhist, Muslim, Sikh	7
BAMER	18
Cared for	17
Carer	10
Pregnant/ Parent with child/children under the age of 5	11
Unemployed	12
LGBT+	9
Living in poverty	10
Homeless	4

Table 1

NB some people fitted into multiple categories

The full breakdown can be found in Appendix 1.

Former experience of rehabilitation services

Former experience of rehabilitation services	Number	Percent
Someone with no experience of rehabilitation services	64	70.3%
A current or former patient of rehabilitation services	15	16.5%
A family member of someone who has been through rehabilitation services	12	13.2%
TOTAL	91	100%

Table 2

We asked each person what their former experience of rehabilitation services was. The majority 70.3% (n=64) had no experience of rehabilitation services, 16.5% (n=15) had been a former patient and 13.2% (n=12) had a family member who had been through rehabilitation services.

What do you think about being in the same place that military personnel are being rehabilitated?

Two thirds of people surveyed (n=60) had no problem being in the same place as military personnel with a further 13 thinking it was a good idea. The reasons given included social aspects, *'We can help each other get better and gain friendships' and 'It could give more social interacting with other people, maybe share different experiences'* and secondly respect for the armed forces, *'I would love it because they are here to protect the country, they are very motivated and very respectful. I don't mind even sharing a room with one'* and *'I have great respect for the forces and would be proud to be in their company'*.

Ten people thought it would be better than the current service at Linden Lodge. The main reason given was better facilities and more experienced staff, *'I think rehabilitation for military is the best in the world, I think it is an advantage' and 'the staff will have proper experience to rehabilitate people with serious injuries'*. The other reasons given were, *'Linden Lodge has been there a long time so is probably getting old' and 'avoids wasting facilities that are already there'*.

Seven people said they would feel safer being there, *'I would have no worries in principle and would find it reassuring because of the security'* and *'I would feel safer if they had armed soldiers on the gates'*.

However 18 people raised concerns. Of these eight people were worried about potential tensions between civilians and military for example, *'I do think it might cause a bit of us and them'* and *'it could be a challenge for both military and NHS people sharing a facility. Military find the public ill-disciplined, and the public might find the military too intimidating'*. Others felt it was important that there are *'different wings'*, *'space between them and civilians'* and *'clear that it is not just for NHS patients'*.

Two people were worried about the higher security e.g. *'I would feel uncomfortable, if they walk around with guns around the site'*, *'I worry a bit about how security on the site might be handled. Answering to uniformed soldiers makes me nervous'* and *'I would not want to run into them on-site on my own'*.

Further there was a feeling that the experiences of military personnel may be different e.g. *'[I] think it's not a good idea because soldiers have been through different experiences'*. Five others had concerns about soldiers with Post Traumatic Stress Disorder (PTSD), *'I am OK with it so long as they are not suffering from PTSD as that might make them a bit unpredictable'* and *'I worry about PTSD and triggering for different people to be around them. Might upset NHS patients to be around if PTSD is triggered'*.

Lastly four people were concerned that The Centre might be *'regimented', 'military style', 'could be less freedom'* and *'will things take time to be processed?'*

Conclusion: Two thirds of people had no problem about being on the same site as military personal and ten felt that it would have better facilities. Seven said they would actually feel safer knowing the military were around. However 18 raised concerns. These were around the themes of the differences in culture between military personal and civilians, sharing the same space/keeping separate, higher security which might make them 'nervous', side effects of PTSD and a more 'regimented' regime.

Recommendation: Ensure that civilians and military patients are aware they will be sharing certain spaces at The Centre. Staff to take into consideration the different needs and culture of military and civilian patients'

What do you think your specific needs would be using this service? Likewise what might be barriers to making use of such a service?

Accommodation

The table below shows the accommodation preferences of the people surveyed.

Accommodation preference	Number
Single room	49
Own toilet/bathroom	34
TV	24
Shared room	17
Homely	14
Shared bathroom	11
Space to see family and friends in own room	11
Chair/sofa in own room	8
Tea and coffee making facilities in own room	8
Smoking area	8
Books	6
Comfy bed	5
Inviting colour scheme	4
A window that can be opened, wardrobe	3 each
Fridge, toaster, laptop, radio, room with a view, desk, large room, access to washing machine	2 each
Cooking facilities, microwave, games console, barber/hairdresser	1 each

Table 3

Over half of the people surveyed would prefer a single room (n=49) and 34 with an en suite bathroom. Ten people stated the reason was for privacy, *'I'm not very choosy, just a room to myself not big, a bit of privacy. If they had an en suite - especially if I am not in the best shape, it would be perfect'*.

Other reasons given for preferring a single room were, *'I would need accommodation like an individual room with an en suite - to cope with body difficulties (managing personal illnesses and injuries like a stoma)'*. *'I need my own room to be able to cope and sleep'* and *'as a women and a member of the South Asian community it needs to be individual accommodation with an en suite bathroom'*.

Having a TV in their room was preferred by 24 people, *'I would like a TV to make me comfortable', 'own bedroom with a TV as the TV in the communal area might be noisy or might be showing something I don't want to watch'*.

In contrast 17 people would prefer to share with one or more other people of the same sex for company, to help them get better and to reduce isolation. These views are expressed in the quotes below,

'I think a single room could be very isolating, seeing other people would be good. I suppose a small room/single or up to 2-3 people'.

'I'd like to be in a dorm because the problem when you are going through therapy you want someone to talk it through with rather than going through it on your own'.

'I would like the choice of a single room or a dormitory (6 people at most) - I would want to choose before getting there, with the option of changing my mind when I got there or while there. It would depend on how much I wanted to socialise'.

Having a room that was *'homely'* or to make your own was mentioned by 14 people, *'if I would need to stay there longer I don't want to feel like in hospital'*, *'I'd want my own little haven'*, *'it needs to feel homely and have some space for personalization, like pictures, posters, warm colours - not just white walls'* and *'cultural needs authentically met'*.

For those with family, a partner or young children, being able to accommodate them in their own private space was important, *'I want a good bed with a couple of chairs so family can spend time with you'*, *'I would need my family to be with me, so some space in the room for family, for my son'* and *'I would want space for a partner or friend to stay if needed'*.

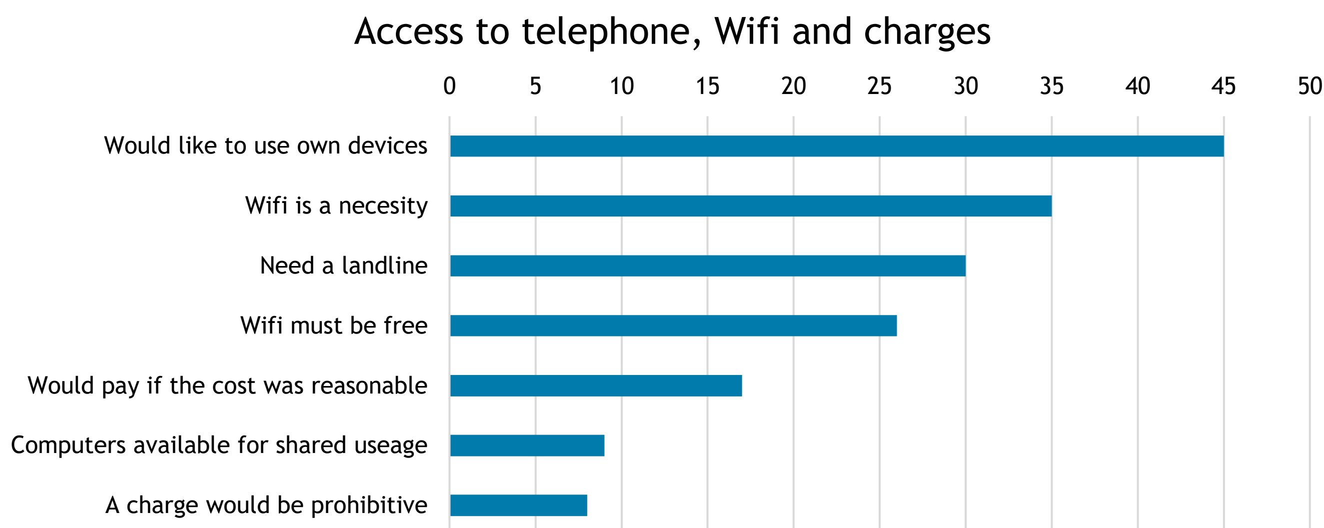
It was also suggested by a couple of people that maintaining their independence and trying to live independently while on site would be helpful, *'An adjustable bed and hoists so you can move independently'*, *'I am a very independent person so I would need this place to be as normal as possible, so if I could cook I would want to do that'* and '*might want to offer some 'moving on' accommodation so you can try on your own'*.

Lastly on accommodation, other facilities such as a comfy chair, tea and coffee making facilities, a smoking area etc. would be appreciated.

Conclusion: People have different accommodation needs based on their sleep patterns, sex, culture and existing health conditions.

Recommendation: Offer a variety of accommodation options and allow patients to give their preference in order to best aid their recovery.

Access to telephone, emails, video calls, broadband speed & cost



Graph 1

The graph above shows the range of communication needs from the people surveyed. Almost half of the people (n=45) have their own phone/laptop which they would like to be able to use. Thirty-five people said that Wi-Fi is a necessity for example because, *'I would expect that [Wi-Fi] be provided. If you were incapacitated in bed you would want to be able to communicate with family and loved ones'* and *'it's a therapy when you talk to someone like your friend'*. Of these, 26 people expected that Wi-Fi would be provided free.

Some people had a specific need for Wi-Fi, *'I have small children so not seeing them (even on screen) would be heart-breaking'*, *'I am here alone in UK, I need to have a contact with family in Poland'*, *'I would want 24 hour internet access as an absolute necessity to… allow for the fact that I have family who live in other time zones'* and *'I would need access to speech recognition software to work equipment. Verbal technologies need to be there to make access possible'*.

Of similar importance (n=30) was a landline in their own room, or for some a communal one, *'at end of corridor'* or *'a call box for people to pay'*. For some people this was of greater importance than Wi-Fi, for example, *'I need a telephone - a landline to talk on. In case I need things from my Mum or from my friends. I need them to be able to telephone me as well. I don't want to be lonely'* and *'I would want a landline. I have a mobile phone but I am hopeless - I don't know my number'* and *'I am not used to technology. (I have been blind for 17 years.) I would like a landline to ring out and receive calls from my family and friends'*.

While 17 people would pay for Wi-Fi at a reasonable charge, eight people said a charge would be prohibitive, *'I don't have the money to pay for it'* and *'I would have difficulty paying for this especially if I wasn't getting my pension paid whilst in hospital'*. It was suggested by eight people that that communal internet/computer facilities could be provided for those without devices.

Conclusion: Being able to communicate with friends and family was seen as a basic necessity for most people who responded to our survey in particular being able to use their own devices with access to free or minimal charge Wi-Fi while at The Centre.

Recommendation: Allow patients to use their own phone/laptop while at The Centre with free Wi-Fi for all patients, and landline in their own room on request. Consider individual needs on a case by case basis, for example voice recognition and 24 hour access.

Accessing specific diets e.g. vegan, halal

The table below shows the specific dietary needs of the people who answered our survey.

Dietary needs	Number
No special diet	40
A menu with choice	16
Healthy balanced diet	15
Vegetarian	5
Gluten free	4
Diabetic	4
Vegan	3
Alcohol	2
No lactose	2
Halal	1
Low residue diet	1
Appropriate implements	1

Table 4

Nearly half had no special dietary requirements and were prepared to eat *'anything'*. Having a daily choice or menu was important to 16 people closely followed by a healthy balanced diet for 15 people. Five people told us they were vegetarian and four that they were vegan. Four people were gluten free and two lactose free. Three people would not eat tripe. Two would like to have the option of having alcohol with their meals. Other special dietary needs are described in the quotes below:

'I have chronic renal failure with low potassium and also gluten-reduced and no dairy - The Centre needs to be able to take this into account'.

'I would expect no cross-contamination with diets for religious reasons, and offer a vegetarian option to help a broad group of people'.

'I'm on a low residue diet now so I would need that to be allowed for to help me manage my stoma'.

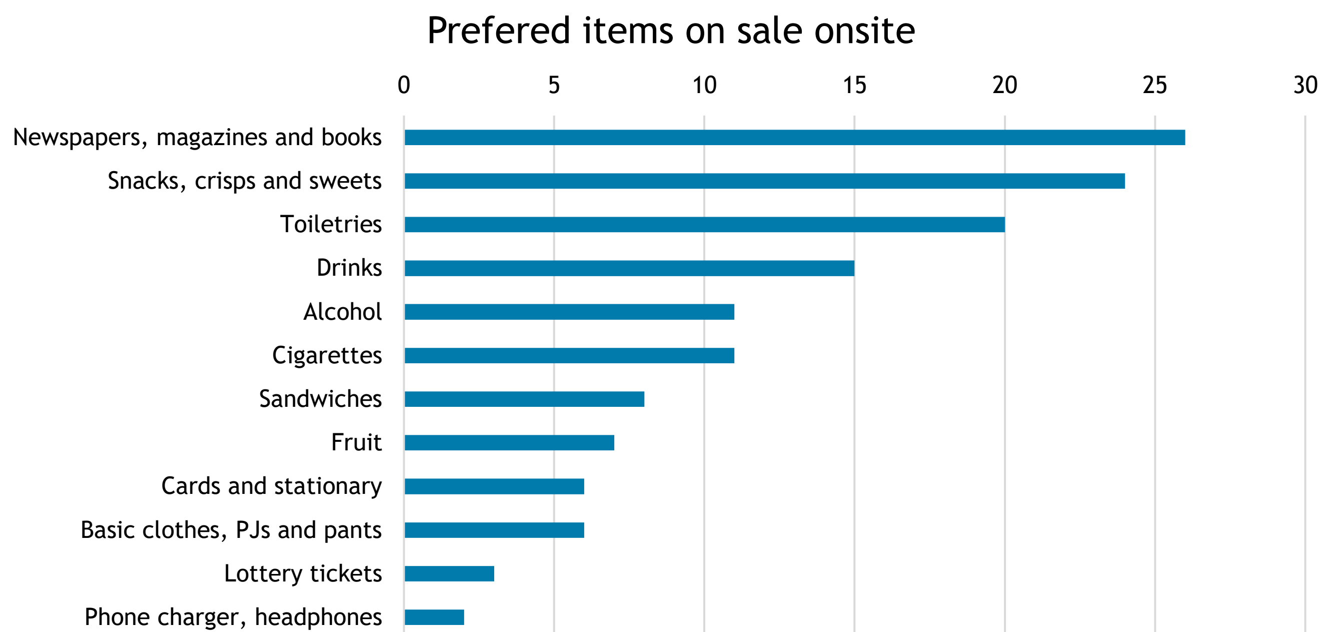
'The right implements to be able to eat my meals. I also worry about swallowing - that means appropriate meals and drinks'.

Conclusion: There were a range of dietary needs across the sample of people surveyed. Both choice and a healthy balanced diet were particularly important to one fifth of people.

Recommendations: Provide a range of choices at mealtimes including healthy balanced diets and occasional 'treats'. Ensure that specific dietary needs are met for individuals and that people have the implements to allow them to eat independently.

Access to shops to buy toiletries, newspapers, magazines, snacks etc. onsite

When asked, 'Would you need a shop onsite?' 76 people agreed they would. The top items they would like to see stocked are shown in the graph below.



Graph 2

The highest answers were newspapers, magazines and books with 26 people requesting this, followed by 24 people wanting snacks, crisps and sweets and 20 toiletries. One person summed up the general feeling from respondents as, *'because of where it is not having local shops, it will be really important for the shop to offer a good range of things'*. For others a shop meant more than just the need for an item, *'God yes! I must have a degree of independence and choice!'* and it's *'part of the rehab'*, *'it keeps people in contact-they start a conversation. Talking makes people better'*.

Specific requests for certain cohorts were made such as, *'for women there should some service that you can order the hygiene products'* and *'I want the shop to have the Nottingham Post so I can follow Nottingham Forest'*.

While eleven people would like or were happy if the shop stocked cigarettes and alcohol, nine people were against the sale of alcohol and seven did not want cigarettes to be sold. There were also mixed feelings about lottery tickets – seen by some as gambling.

In addition to this *'hospital shop'* 13 people would like to see a café on site, *'Also a coffee shop to make things feel more normal. Want to be able to keep up with what's going on'* and *'not just for the patient but for families visiting'*. Five people asked for a chemist, five to be able to order items online (perhaps reflecting how shopping has changed due to lockdown) and have them delivered to them at The Centre, four for a cash machine, two each for a restaurant, hairdresser/barber and library and one each to be able to rent movies and have a gaming kiosk.

Conclusion: The answers to this question illustrated the range of needs people have not only for the items, but to be able to have independence, choice, have a walk and meet others.

Recommendation: At minimum a hospital shop with basic items is required. A café / restaurant is also important for both patients and visitors.

Accessing inside and outside space independently, and off-site facilities

Sixty-three people said that accessing outside space was important to them. Primarily for fresh air, *'I would like some outside space, garden and be able to go for a walk to have fresh air'* and *'that would be one of the most important things, if I was in a wheel chair to be able to get out into a garden, if I couldn't I would probably kill myself!'* Ten people suggested that an outside gym or pool would be nice in addition to the gardens, *'maybe outside exercise equipment to do your exercises on' and 'being outdoors should be part of therapy, I think there should be pool there'*. Other suggestions included a water feature, picnic areas for families, a sensory garden and bird feeders, *'room to socialise, classes, art sessions, animations'* and five people would like an outside smoking area.

For others it was seen as important for their mental health, *'I absolutely need access to outside spaces on my own to help with my mental health'*, *'Being stuck in a room for weeks is too hard on mental health'*, *'Can't think of anything better than to get outside and heal yourself'* and *'I have got to have an outside space to just let my head breathe where I can walk away to'*.

Forty-five people recognised the importance of accessibility and suggested the need for mobility scooters, wheel chairs, benches, grab rails, lifts, even ground and lowered pavements and, *'benches so people can rest and relax'*. *'All the places should be wheelchair friendly, ramps instead of stairs. No one should be limited'*. *'As much independence as possible – I'd want to be independent and be able to explore on my own'*. For 19 people having assistance from staff and volunteers was very important, *'it would be nice to go out and have assistance in doing so', 'There should be a park or garden outside and there should be support for people to go out (even if you are in a wheelchair)'*. *'There should be additional help for people who are not mobile to get outside, maybe volunteers?'*

Over a fifth of people (n=19) would like to be able to go off site. The reasons given included, *'my mental health would suffer if I would be just onsite for more than 2-3 weeks, so off site trips would be a must'*, *'if I could go off site on my own then I would I like to play snooker or go to the cinema or go for a walk'* and for one, *'depending on how injured I was, it would be nice to go down the pub for a Sunday session'*. Others felt they might require assistance to go off site, *'able to be escorted to Loughborough so you can keep a toe in normal life'*, *'transport provided if possible - to go off-site, e.g. a shuttle service'*.

A few had individual needs, *'I would have to be shown where places were, inside and outside, so that I could remember where to go. I would need flat surfaces and lowered pavements. I would need to be on the ground floor (though I prefer to see the view from higher up); a lift would not help as I would not be able to see the buttons'*.

Conclusion: Being able to access outside space was essential for over one third of people surveyed to aid their physical and mental recovery. People felt that outside spaces would need to be accessible and where possible wheelchairs and mobility scooters provided. In addition, being able to get off site was important to one fifth of people.

Recommendations: Provide easy independent access to outside space with a large range of facilities to meet different people's needs.

Accessing religious spaces to practice your religion

Over two thirds of people (n=67) said that a space for people to practice their religion was of importance though not necessarily for them personally, *'do the same as in hospitals, with one room for all religions. No icons etc. just a vase of flowers'*. *'There would be no need for visual symbols – they get in the way'*. *'A cosy room, like the one at City Hospital'*. *'All faiths welcome'* and *'a multi-use prayer room or space is required, this will help some people to recover, and it is a part of the way some people heal'*.

However, there was also recognition that it may not be possible to accommodate all faiths in one room, *'A Christian chapel, and separate from other religions. I would prefer it not to be multi-faith'*. *'Muslim patients would need to have an ablution facility nearby so that they could observe their prayer sessions'*. *'I am worried that that some religious [people] might feel excluded and how The Centre would accommodate all?'* and *'Have space that is culturally appropriate with the resources, like Bible, Quran, devotion books, or able to access over internet'*.

Nine people described how important it was to them personally, a *'place where you can restore and pray'* and *'I would like to have a special place to practice my religion, because I'm a Christian'*. For others it was the sense of community that religion brings, *'I need someone to take me to my church. I normally go with my Mum and see friends there as well. Also a space inside [The Centre] where my friends could come and worship with me!'*, *'Prayer room is very important for me. This maybe could create a community'*.

Twelve people put the emphasis on someone to talk to rather than a room to pray, *'A quiet room, with someone sympathetic to talk to, and to listen to me'*, *'perhaps a chaplain able and willing to talk to me when I am feeling down'* and it *'would be good to offer appointments to access priests, vicars, imams'*.

Conclusion: Both religious and non-religious people recognised the importance of having a space for people to practice their belief system. However, there were conflicting views as to whether a neutral prayer room would be appropriate to all. For others it was more important to have someone to talk to and suggestions were made to have a range of faith leaders visiting for this purpose.

Recommendations: Provide at least a multi faith room to allow people to practise their religion as well as facilitating access to visiting faith leaders. Consider whether a separate room would be required for certain faiths.

Privacy

The table below shows the privacy needs of people we spoke to.

Privacy needs	Number
I require privacy – my own space	51
Please knock before you enter my room	17
I would like to speak to health professionals in a private space	16
I would like a safe place to keep my things	6

Table 5

More than half of the people surveyed (n=51) said they need their own private space, *'I wouldn't be able to hack it. Sometimes I have to walk off so it would be bad if there was nowhere to go'*, *'Absolute privacy. I would decide what I wanted to do, and when – nobody decides for me'* and *'I am very very private, a space where I can be on my own, maybe quiet rooms to be away from other people, literally alone'*.

Seventeen people said it was important for them that staff knock before entering their room, *'people just bursting in is embarrassing'*, *'no one barging in' and 'Knock first! That would be polite.'* A similar number of people (n=16) would like to be able to discuss their condition in private with health professionals, *'if there is a need to talk to someone it should be done in a consultation room not in shared spaces'* and *'if I was talking about personal stuff with a doctor to have a private place to do this'*. However this was not the case for everyone, *'If I am in my bed and I cannot move then I don't want to go anywhere so tell me here'*, *'just draw the curtains that would be fine. That is not important for me'*.

It was also recognised that certain people may have specific privacy needs, for example, *'make sure nurses who help are the same sex as the patient'*, *'the texture of clothes can be difficult for me and I can't cope'* and *'I wouldn't be comfortable using bedpans on a ward.'* Lastly one person shared a different concern, *'worry about the needs of gay patients, transgender patients, to make sure they can be who they are without bullying'*.

Conclusion: Different individuals have different privacy needs, where some people have no need for a space of their own, others require this. Knocking before entry was seen as polite and important to a number of people, as was being able to speak to health professionals about their condition confidentially.

Recommendations: Address people's privacy needs on an individual basis, ensure consultation rooms are provided if requested.

Support for care of my dependents (e.g. children or another person you care for)

Eleven people who answered this survey were either pregnant or had a child under the age of five years. People with babies felt that mother and baby should be together as explained below:

'As I have small baby there should be support for me to be with baby all the time. Even with help but with me at all times. It is important for mother baby bonding (my baby is 3 weeks old)'.

'As a single mother with a toddler, maybe they could accommodate the baby with you'.

'I would need someone to care for my child. I would want them to be with me with some additional help, depends on my mobility'.

For parents with older children most would make their own arrangements, *'my family would take over - I would arrange that', 'I would probably sort this out myself'*, *'my children would stay at home I'd leave them with my parents'*. However, this brought about other worries, *'I'd find it hard without him [my son], not having a cuddle or play or taking him out in the car. I would be torn as I know that I would have to be focussed and get better. He is 4 years old'*, *'I would want them to be able to come in to see me. So I can read stories, give them a cuddle. Children need to be able to see a parent'* and *'I think without mental health support this stay could become traumatic for my children'*.

Schooling for children was also a concern for some parents, *'A collective own private space for my dependents. So we can stay together. Some sort of nursery/schooling?'*, *'if my dependent children were out there [at The Centre], they would need schooling and some kind of entertainment'* and *'if the centre could provide some child care or after school care that would be really good'*.

Ten further people were carers for others and stated the support they would need, *'I need to know that my parents and my kids will be fine when I am gone - social services need to be in touch so kids are still attending school etc.'*, *'I would want an office or representative to guide me about what I could do, to signpost me to services who can offer help to the people I care for. Keep in contact with them to explain what is needed. Help with emotional issues too'*, *'I am a carer so I would expect them to be able to help me arrange continuity of care through the rehab centre'*, *'the centre needs*

to offer some support for setting up care and help, because the patient might not be in a position to help'.

One young person described their caring responsibilities as, *'I (aged 15) look after my younger brother he is 10. Possibly my mum could look after him but sometimes she is out working. If no one could look after him then he might have to come with me'*.

Three people also mentioned the importance of pets, *'If I was there for a long time it might be too much for neighbours, relative or friends and kennels are very expensive'* and *'children and pets need to be able to come along to help people recover'*.

Conclusion: Parents with babies felt they should be able to bring them with them and extra support provided on site, most parents with young children said they would be able to make their own arrangements but for some this would present a problem. In these incidences the parent would need support and guidance from social services. Similarly, people caring for adults would need guidance and support to access services to do this, particularly if they were too unwell to make the arrangements themselves.

Recommendation: Ensure there is provision for parents to care for babies on site. Provide social care guidance to support and care for young children and adults in order to reduce the stress on the patient.

Other health and social care needs (e.g. support for my diabetes, facilities for my carer to be with me, accessing chronic care e.g. cancer treatment)

Seven people described specific ongoing health needs that they would need support with while at The Centre, these included, *'I have a lung condition and I have a consultant who normally I see'*, *'I have regular visits to QMC and I think transport should be provided for them'*, *'I had a quadruple heart bypass that failed so I would need careful monitoring'*, *'for myself, I would need to be able to order stoma supplies'*, *'I can manage my diabetes myself now but I may not always be able to'* and *'might be dead if other treatment not continued'*.

Twenty-three people stressed the need to have a GP/Medical Centre/Nurse on site, *'there should be medical services on-site - nurses and doctors. I have regular blood tests as I take warfarin for my heart condition (hereditary irregular heart beat)'*, *'A medical centre would be necessary for routine care of people with extended stays at the RC'* and *'I don't have any long term need, but there should be GP accessible'*.

Three people described specific barriers that could hamper them from going to The Centre, these were, *'I would worry if I couldn't continue to attend meetings around transgender health to help me cope'* and *'will they understand where I am coming from, as a BME patient? This is really important to offer. It needs a culturally reflective workforce and intervention. Communication is key to help people cope and feel understood'* and *'I would expect them all [my medication and treatment] to be provided for whilst I am getting rehab. If they cannot then I cannot go along'*.

Conclusion: While some people assumed that their regular treatment and repeat prescriptions would continue others were less confident and stressed the need for good communication and transfer between existing and new health professionals.

Recommendation: Ensure swift transfer of medical files to ensure on site staff have access to the patients' medical history, continue to provide repeat prescriptions and GP check-ups as required where possible on site or with transport provided for specialist services. Consideration needs to be made for people who require other ongoing treatments either providing transport to the service or by bringing medical specialists in.

Support with my existing or new mental health condition

Fifteen people told us they have an existing mental health condition that they would like/need support with. Some of the examples are described by the quotes below:

Mental Health support needs now

'I have depression, stress and worry so mental health support is important'.

'There should be someone accessible to talk to about the mental health. Those meetings should be scheduled as well so I don't need to reach out'.

'I would need access to my family. I do get depressed when I feel lonely – the rehab centre is very far out'.

'I would want to have unrestricted visits from friends and family'.

'I do get called by a CAMHS worker every two weeks, I'd need to talk to them every 2 weeks'.

'Recognising that I have good days and I have bad days, and sometimes I won't be able to cope with rehab objectives'.

'I want someone to be able to talk to get things off my chest. Also able to offer some more intense therapy. Able to handle coping with changes to my body and identity'.

These people went on to describe aspects of therapy they had received before that didn't work for them as shown in the table below:

Things that don't work for me

'I don't think group therapy is the best one. I would not like to talk to other people'.

'I don't want to go onto a waiting list for getting help. When people need services they have already been through enough trauma and they need help now!'.

'If it takes a long time to see a professional over mental health issues it would undermine the value of rehabilitation to me'.

'If they keep changing who I see I wouldn't bother'.

'Help with coping with being away from family and work - recognising the struggle'.

'Need to be able to offer more than short courses of therapy. Don't waste time offering a short course - it won't be any real help'.

'Female, experienced, not too young'.

'No Tai-Chi as it is against my Christian belief'.

Sixty-two people described what they thought their future needs might be:

Things that don't work for me

'If I developed a new mental health condition while I was there, I would want someone to be available for me to speak to and to give me all the help I needed. Talking therapies should be available'.

'I don't know how I would be if I was in that place, if I was in a wheelchair I wouldn't be talking like this and that would change my life completely and I would probably need some counselling'.

'The centre needs to be laid out and considered in its design: natural light, a homely place. Plenty of information on route to go down for new mental health problems'.

‘There should be support for people who develop mental health conditions; people to talk to, to listen to them’.

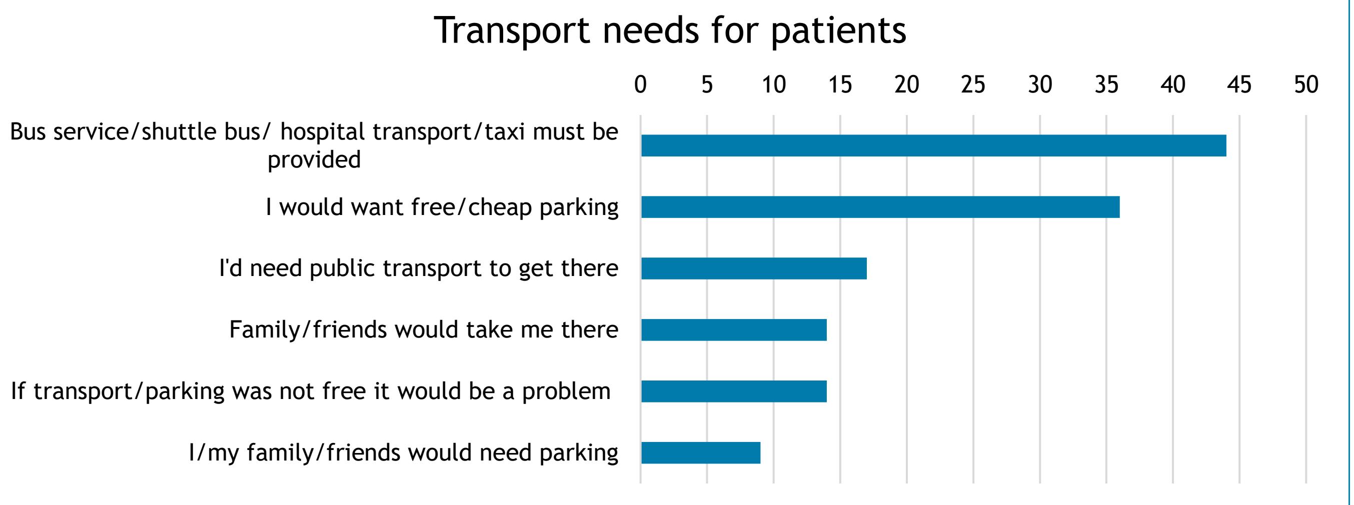
‘I need them to be able to offer support for mental health, because you don't know how things might push you’.

Conclusion: It was clear that those people with existing mental health conditions would need continued support ideally from their exiting service/contacts to ensure continuity of care. For some, access to friends and family was an important aspect of maintaining their wellbeing. Many people imagined needing new mental health support as a result of their illness or injury and that mental rehabilitation was as important as physical rehabilitation.

Recommendation: Continue to provide mental health support for people with existing conditions from the service they are in contact with. Where new services are provided ensure that this is tailored to the needs of the individual.

Cost of public & personal transport: convenience and frequency, parking

The graph below shows the transport needs of the people we spoke to:



Graph 3

Nearly half of the people (n=44) said a bus service, shuttle bus, hospital transport or taxi would need to be provided to transport patients to The Centre, *‘Public transport is important for me as I have no private transport’*, *‘May be additional transport should be provided. It is not very good location if someone is using public transport’* and *‘I would most likely have to go on the bus as my Dad is the only one who drives and he is only there on the weekend’*.

The cost of public transport/car parking would be prohibitive to 14 people, *‘[I] worry about the cost of transport, I would go without it [treatment] because I couldn't afford it’*, *‘cost might stop me accepting help if say I need to take taxis there and back’*, *‘yes cost it is a worry, the price of public transport, especially train’* and *‘If I as a patient have to go to and fro, then public transport costs become critical to being able to access help’*.

Thirty-six people would want free or cheap parking, *‘don’t take the “Mick” over parking!’*, *‘Don’t “fleece” people as they do in hospitals’* and *‘when I have been with my child in hospital we spend almost £60 for parking it was terrible. Paid parking when you have no other option but pay is devastating for family’*.

Distance was also a worry for some, *'the place is very far away I don't know exactly how I could get there'* and *'there should be a bus services to this place, it's very far away from where I live'*. Concerns were also raised about how much walking from the bus stop there would be, *'Loughborough is a long way, and catching lots of buses would be a no-no for me. I need to be able to get directly there - don't expect to have to walk!'*, *'Again it depends how much walking would be involved to get on the public transport so might need taxis but if there was a bus stop right next to the place and you could get connected to other buses that would be okay'*.

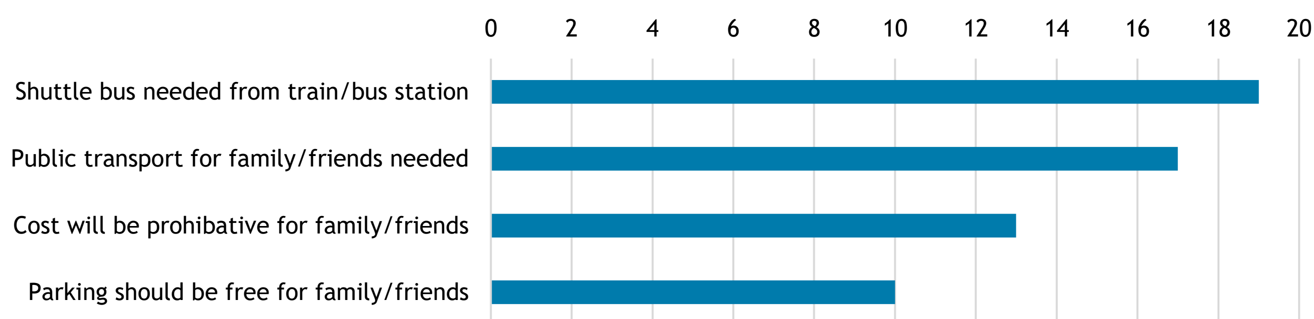
Other people had individual needs and concerns, *'my family do not speak English and it would be difficult for them to get there'*, *'public transport would only be feasible if I were not having dizzy spells'*, *'many of my friends don't drive and for older friends who no longer have cars, getting to the centre from Nottingham would be a problem'*, *'if you were feeling fragile, or even unwell, would you want to be so far away? Away from your own surroundings – this would impact on your physical and mental health because nothing and no one would be familiar'*, *'[it would be barrier for me] if they didn't have any space to charge or store mobility scooters to be able to let me get around. Need secure storage'*, *'I don't know how I would get there, I would feel scared'* and *'if I am coming a long distance I won't be able to start early'*.

Conclusion: It is essential that public transport is provided preferably in the form of a regular shuttle service from the train and bus station. Long stay patients require free car parking close to the entrance.

Recommendation: Provide public transport to the door of The Centre, preferably by a shuttle service from the train and bus stations. Provide free parking for patients.

Transport for yourself/friends and relatives - getting there and back for ongoing treatment

The graph below shows the transport needs for family and friends of people who completed our survey.



Graph 4

As before a shuttle bus from the bus/train station was seen as very important by 19 people, *'because of the location if there is no shuttle service it will affect my family visiting'* and *'some of my family members don't drive and without regular public transport they would not be able to reach me'*. The cost of transport was also seen as a barrier for visitors by 13 people, *'if it would be too expensive it will impact how often people visit me'*, *'cost can be hard on some friends and relatives who are on benefits and might mean they cannot visit'* and *'In my case my partner doesn't drive so she would have to use public transport it would a pain and it would be expensive'* People also worried about the cost of taxis, *'If public transport was not available and they had no car, taxis would be expensive'*.

Distance and rural location was seen as a barrier for visitors too, *'the downside to the rehab centre could be difficulty in getting there'*, *'it's not a convenient location'*, *'the distance would be an issue for people coming from Nottingham'* and *'it would be hard for my Mum, it would be a little bit difficult for her and she doesn't drive'*.

The cost of parking came up again as an issue for family and friends in some cases impacting on the number of visits patients could expect, *'paid parking and paid transport would affect how often family would be visiting'*, *'my friends and family are using their own cars. Parking should be free also for family visiting'* and *'If there was paid parking it would affect the length of a stay my visitors'*.

Other issues that were raised are listed below:

'I think there could be a transport for family. If my family would come to visit me someone need to pick them up from airport'.

'Many of my friends don't drive and for older friends who no longer have cars, getting to the centre from Nottingham would be a problem. Public transport would be difficult for most of my friends to use'.

'My partner might not be able to drive or use public transport so there would need to be some kind of assisted travel facility'.

'Public transport would be stressful for my partner and would be quite a journey with my son [who is autistic]. Dealing with the public transport, getting there for the allocated time, and getting there early for the bus then waiting and you don't know how long it will take etc.'.

'Worries around reliability of public transport, getting there in time. Also transport offered - we need to be able to get in with disabilities'.

'Worries about disruption around education for children to visit'.

'Always awkward to park - need enough space. They need to let people who have disability have proper parking spaces or spaces where disabled people can get'.

Conclusion: Public transport and shuttle buses are required for family and friends to visit patients at The Centre. In some cases, people felt the cost of transport and parking would impact on the number of and frequency of visits they have. For those whose friends and relatives who do not drive/do not have a vehicle the logistics of using public transport was also an issue for example, journey time, disabled access, walk from bus stop etc.

Recommendation: Provide a regular shuttle service for family and friends from the bus and train station to the door of The Centre to facilitate access.

Accommodation for your family and friends

The table below shows what the accommodation needs are for family and friends of the people we spoke to.

Family and friend accommodation needs	Number
Accommodation for family/friends is a necessity for me	35
It would be nice to have this accommodation option	24
Hostel rather than hotel prices or free for close family	23
My family/friends would not need to stay	14
There needs to be things for children to do	4

Table 6

For over a third of people (n=35) additional accommodation was a necessity. Firstly to provide emotional support, *'I don't think I could stay more than few days without seeing my children this would seriously affect my mental state'*, *'If there was no accommodation for my kids I would be very anxious'* and *'It would do me no end of good to be able to have a friend come over from time to time, to provide company and activity'*.

Secondly for practical reasons, *'I think my family would stay as my mother is in Slovakia, when coming she would need to stay at least few days maybe even for full length of my stay'*, *'because it is far away from city and some of my family travel by buses I think they would need to stay on site when visiting me'* *and* *'I think my family members would like to stay with me as it is quite a distance from Newark'*.

Cost of this accommodation was a concern to 23 people, *'It should be basic hostel, maybe paid to avoid people staying over just because it is free, - low cost'*, *'A nominal charge to cover the cost of laundry and cleaning'* and *'charge if they can afford to pay'*.

Twenty-four people said it would be nice to have this option on site but otherwise family and friends would stay in a hostel, B&B or cheap hotel nearby. Fourteen people had no need for onsite accommodation for family and friends, *'I don't think any of my family members would stay overnight, if they would gather together it would be difficult for other people'*, *'My family live nearby so I don't think they would use it'* and *'I wouldn't want them staying on-site'*.

Other needs are described below:

'I have small child and there should be some playground so I could have a positive time with my child'.

'Security so it is not one big party'.

'It needs to be accessible too, as you can't assume that friends and relatives are able-bodied'.

'Some attraction for families so they can focus on something else then rehabilitation. Bingo maybe'.

'Some play area for my kids. If there was nothing for kids there to do it would affect how often they would visit me'.

Conclusion: In order to provide emotional support and reduce the inconvenience of The Centre being out of the way, over one third of people require accommodation for family and friends. Cost of this accommodation would be a barrier if it was hotel, rather than hostel prices, so this needs to be factored in.

Recommendation: Provide onsite accommodation for family and friends at reasonable rates

Support/opposition of the proposal to create NHS RC at Stanford Hall

The table below shows the level of the support the people we spoke to have for NHS RC.

Support of proposal to create NHS RC at Stanford Hall Estate	Number	Percent
Strongly support	57	62.6%
Slightly support	24	26.4%
Neither support or oppose	8	8.8%
Slightly oppose	1	1.1%
Strongly oppose	1	1.1%
TOTAL	91	100%

Table 7

Nearly two-thirds of people (n=57) strongly support the creation of the NHS RC with over a quarter (n=24) responding slightly support. Ten people were either not sure or slightly or strongly opposed to this proposal. When asked to elaborate on their answers, views fell into positives and negatives as shown below.

Positive comments

'I think patients who would be treated in this place will get better quicker with so packed rehabilitation in one place'.

'It seems that new centre will be better and modern. It is nice countryside area'.

'I think it is very good idea to make a highly specialist facility to treat people'.

'I fully support because people need access to and will take a pressure off the NHS buildings'.

'A whole team of specialists meeting different needs all in one place would really benefit patients. Dealing with a whole person to achieve a good quality'.

'The idea for Stanford Hall is fairly central and it will bring together expertise'.

'The defence centre is already there and I like the idea of using an existing space instead of using tax payers money to build it somewhere from zero'.

'It is military centre so it will be much better'.

'The more NHS buildings, the better - the more spaces for patients, the better. The fewer people suffering, the better'.

'It gives people time to get back on their feet instead of being stuck in a hospital'.

'A real sense of camaraderie and community around being with others who are being rehabilitated'.

'It would be nicer to look out the window at a nicer surroundings'.

'I think it is a good idea because it is in a quiet place not a busy, busy place, sometimes people need a quiet place to get better'.

'It would be better for your well-being some of the City hospitals have horrible views out of the window'.

'It will help people out. Being away from life and just focus on rehabilitation would be beneficial'.

Negative comments

'Translator services on demand should be provided for non-English-speaking people - in person not by phone'.

'More staff will be needed'.

'Location is not great, I use public transport that is why I gave this answer'.

'I don't have a car so I would worry to be placed in this centre as it is not central and my family would have a problems to reach me'.

'I am slightly nervous about public transport links might not be efficient and cause a problems, it might be not efficient for patients'.

'I don't want it to feel military'.

'The main problems would be loneliness because of where it is and people having to spend lots of money on transport because it's hard to get to'.

'If it is a cost-cutting exercise, I am against it'.

'So long as everything was properly co-ordinated, with patients' records to hand, it would be a huge help'.

'City Hospital is much more convenient to get to'.

'I hope the NHS doesn't lose good staff in bringing facilities together'.

'It would be nice if there was one in the City as well, not a full move'.

'It needs to be a large enough facility to be able to host enough people to be useful - don't want it to be a lottery if you get care'.

Unanswered questions

People who were interviewed raised a number of questions. It might be useful to include these in a 'Frequently asked questions' booklet if the proposal for The Centre goes ahead.

- I don't understand the context in which this is being built how necessary is it to have this facility?
- Would the facilities be relevant for civilians?
- What would the staffing be? How many staff would there be?
- If there were another war – always a possibility – what would happen to the NHS civilian patients?
- Is Linden Lodge to be closed?
- When will it be opening?
- I'm not sure about the facts, why is it being moved?
- Could he [my partner] stay in our motorhome at The Centre?
- Why is it being moved in the first place?
- Is the contract to be given out fairly, or will politicians decide?
- Is the centre going to be cost effective for the number of patients?
- I would want to know far more about the plans and proposals
- [Could there be] a simple camping area or the like?
- What mode(s) of transport would be available for visitors? Who would pay for taxis if these were necessary?
- How do military families of military personnel cope currently with transport issues?
- Could there be a Shuttle bus?
- What would access be like for people who live out in the countryside?
- Would bookable transport be available like Easylink or Arriva?
- Is it down a country lane?
- Can public transport get you to The Centre?
- Can I see the same people to help me with my existing mental health condition?
- Would people who need dialysis be able to come in?
- Who would make the arrangements for support of dependents (children and parents people care for) would it be the patient or The Centre itself?
- Is the NHS going to impose on the military or be quite separate? Are there separate regimes? What's the agreement going to be? Who's going to be the "holder of the key"?
- Will there be curfews for going off campus?
- Will there be a space to smoke outside?
- Would someone keep track of me if I go offsite?
- Depending on my ability, would someone be able to shop for me?
- How do patients get cash?
- Would I be able to order items online and have them delivered to the site?
- Will there be an additional charge for charging my mobile phone?
- Will there be a good O2 signal?

Conclusions

Two thirds of people had no problem about being on the same site as military personal and ten felt that it would have better facilities. Seven said they would actually feel safer knowing the military were around. However, 18 raised concerns. These were around the themes of the different culture between military personal and civilians, sharing the same space/keeping separate, higher security which might make them 'nervous', side effects of PTSD and a more 'regimented' regime.

People have different accommodation needs based on their sleep patterns, sex, culture and existing health conditions, so it is important to provide a variety of options.

Being able to communicate with friends and family was seen as a basic necessity for most people, in particular being able to use their own devices with access to free or minimal charge Wi-Fi while at The Centre.

There were a range of dietary needs across the sample of people surveyed. Both choice and a healthy balanced diet were particularly important to one fifth of people.

It is important that the onsite shop stocks a range of items in order to meet the variety of needs of patients, family and friends. Access to an onsite shop also provides a sense of independence, choice, exercise and social contact with others.

Being able to access outside space was essential for over one third of people surveyed to aid their physical and mental recovery. They felt that outside spaces would need to be accessible and where possible provide wheelchairs and mobility scooters.

Both religious and non-religious people recognised the importance of having a space for people to practice their belief system. However, there were conflicting views as to whether a neutral prayer room would be appropriate to all. For others it was more important to have someone to talk to. Suggestions were made to have a range of faith leaders visiting for this purpose.

Different individuals have different privacy needs: where some people have no need for a space of their own, others require this. Knocking before entry was seen as polite and important to a number of people, as was being able to speak to health professionals about their condition confidentially.

Parents with babies felt they should be able to bring them with them and extra support provided on site. Most parents with young children said they would be able to make their own arrangements but for some this would present a problem. In these instances the parent would need support and guidance from social services. Similarly, people caring for adults would need guidance and support to access services to do this, particularly if they were too unwell to make the arrangements themselves.

While some people assumed that their regular treatment and repeat prescriptions would continue, others were less confident and stressed the need for good communication and transfer of medical files between existing and new health professionals.

It was clear that those people with existing mental health conditions would need continued support ideally from their existing service/contacts to ensure continuity of care. For some, access to friends and family was an important aspect of maintaining their mental wellbeing. Many people imagined needing new mental health support as a result of their illness or injury and that mental rehabilitation was as important as physical rehabilitation.

It is essential that public transport is provided, preferably in the form of a regular shuttle service from the train and bus station. Long stay patients require free car parking close to the entrance.

Public transport and shuttle buses are required for family and friends to visit patients at The Centre. In some cases, people felt the cost of transport and parking would impact on the number and frequency of visits they have. For those whose friends and relatives who do not drive/do not have a vehicle, the logistics of using public transport was also an issue, for example journey time, disabled access, the length of the walk from bus stop, etc.

In order to provide emotional support, and reduce the inconvenience of The Centre being out of the way, over a one third of people require accommodation for family and friends. Cost of this accommodation would be a barrier for some if it was charged at hotel rather than hostel prices.

Recommendations

In order to address these specific needs and barriers to access, it is recommended that the CCG takes the following actions:

Specific needs to consider

- Continue to provide mental health support for people with existing conditions from the service they are in contact with. Where new services are provided, ensure that this is tailored to the needs of the individual
- Where new mental health conditions arise, ensure that people are able to talk to someone about this.
- Ensure there is provision for parents to care for babies on site. Provide social care guidance to support and care for young children and adults in order to reduce the stress on the patient.
- Offer a variety of accommodation options and allow patients to give their preference to assist their recovery.
- Allow patients to use their own phone/laptop while at The Centre with free Wi-Fi access for all patients, and landline in their own room on request. Consider individual needs on a case-by-case basis for example voice recognition and 24-hour access.
- Provide easy independent access to outside space with a large range of facilities to meet different people's needs.
- Ensure that civilians and military patients are aware they will be sharing certain spaces at The Centre. Staff to consider the different needs and culture of military and civilian patients.
- Provide a range of choices at mealtimes including healthy balanced diets and occasional 'treats'. Ensure that specific dietary needs are met for individuals and that people have the implements to allow them to eat independently.
- Provide at least a multi-faith room to allow people to practise their religion as well as facilitating accessing to visiting faith leaders. Consider whether a separate room would be required for certain faiths.
- Address people's privacy needs on an individual basis and ensure there are private places to speak to health professionals and relatives if requested.
- Ensure swift transfer of medical files to ensure on site staff have access to the patients' medical history, and continue to provide repeat prescriptions and GP check-ups as required where possible on site or with transport provided for specialist services. Consideration needs to be made for people who require other ongoing treatment, either providing transport to their facility or bringing in medical specialists.
- Provide public transport to the door of The Centre, preferably by a shuttle service from the train and bus stations for patients, family and friends. Provide free parking for patients.
- Provide onsite accommodation for family and friends at reasonable rates.
- At minimum a hospital shop with basic items is required. A café / restaurant is also important for both patients and visitors.

Barriers

- Provide information about The Centre to patients to address concerns about being on the same site as military personnel.
- Ensure that all patients have affordable ways to communicate with their family and friends.
- Ensure that affordable public transport to The Centre is available.

Appendix 1: Demographics of respondents

District	Number	Percent
Ashfield	14	15.4%
Bassetlaw	1	1.1%
Broxtowe	6	6.6%
Gedling	25	27.5%
Mansfield	6	6.6%
Newark & Sherwood	13	14.3%
Nottingham City	22	24.2%
Rushcliffe	4	4.4%
Total	**91**	**100.0%**

Age Group	Number	Percent
1 - 15	8	8.8%
16-17	3	3.3%
18-24	11	12.1%
25-34	13	14.3%
35-44	13	14.3%
45-54	10	11.0%
55-64	11	12.1%
65-74	7	7.7%
75-85	11	12.1%
85+	4	4.4%
Total	**91**	**100.0%**

Gender	Number	Percent
Female	47	51.6%
Male	43	47.3%
Not answered	1	1.1%
Total	**91**	**100.0%**

Sexuality	Number	Percent
Heterosexual	68	81.9%
Homosexual	6	7.2%
Prefer not to say	4	4.8%
Asexual	2	2.4%
Bisexual	2	2.4%
Not answered	1	1.2%
Total	**83**	**100.0%**

Are you a carer for anyone?	Number	Percent
No	80	87.9%
Yes	10	11.0%
Not answered	1	1.1%
Total	**91**	**100.0%**

Are you a cared for by anyone?	Number	Percent
No	74	81.3%
Yes	17	18.7%
Total	**91**	**100.0%**

Pregnant/children age < 5	Number	Percent
No	78	85.7%
Yes	11	12.1%
Not answered	2	2.2%
Total	**91**	**100.0%**

Homeless	Number	Percent
No	87	95.6%
Yes	4	4.4%
Total	**91**	**100.0%**

Employment status	Number	Percent
Retired	24	26.4%
Full time	23	25.3%
Student	16	17.6%
Part time	13	14.3%
Not working	12	13.2%
Unable to work	3	3.3%
Total	**91**	**100.0%**

Ethnicity	Number	Percent
White	73	80.2%
Black	5	5.5%
Mixed/Multiple ethnic	4	4.4%
South Asian	3	3.3%
Asian	2	2.2%
Gypsy or Traveller	1	1.1%
Other	1	1.1%
White - Latin American	1	1.1%
White - of mixed heritage	1	1.1%
Total	**91**	**100.0%**

Religion	Number	Percent
Christian (all denominations)	42	46.2%
No religion	35	38.5%
Prefer not to say	5	5.5%
Atheist	2	2.2%
Muslim	2	2.2%
Sikh	2	2.2%
Buddhist	1	1.1%
Other - Agnostic	1	1.1%
Other - Spirituality	1	1.1%
Total	**91**	**100.0%**

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Health Scrutiny Committee
15 October 2020

Work Programme

Report of the Head of Legal and Governance

1. Purpose

1.1 To consider the Committee's work programme for 2020/21 based on areas of work identified by the Committee at previous meetings and any further suggestions raised at this meeting.

2. Action required

2.1 The Committee is asked to note the work that is currently planned for the municipal year 2020/21 and make amendments to this programme as appropriate.

3. Background information

3.1 The purpose of the Health Scrutiny Committee is to act as a lever to improve the health of local people. The role includes:

- strengthening the voice of local people in decision making, through democratically elected councillors, to ensure that their needs and experiences are considered as part of the commissioning and delivery of health services;
- taking a strategic overview of the integration of health, including public health, and social care;
- proactively seeking information about the performance of local health services and challenging and testing information provided to it by health service commissioners and providers; and
- being part of the accountability of the whole health system and engaging with the commissioners and providers of health services and other relevant partners such as the Care Quality Commission and Healthwatch.

3.2 As well as the broad powers held by all overview and scrutiny committees, committees carrying out health scrutiny hold the following additional powers and rights:

- to review any matter relating to the planning, provision and operation of health services in the area;
- to require information from certain health bodies[1] about the planning, provision and operation of health services in the area;
- to require attendance at meetings from members and employees working in certain health bodies[1];
- to make reports and recommendations to clinical commissioning groups, NHS England and local authorities as commissioners of NHS and/or public

[1] This applies to clinical commissioning groups; NHS England; local authorities as commissioners and/or providers of NHS or public health services; GP practices and other providers of primary care including pharmacists, opticians and dentists; and private, voluntary sector and third sector bodies commissioned to provide NHS or public health services.

health services about the planning, provision and operation of health services in the area, and expect a response within 28 days (they are not required to accept or implement recommendations);
- to be consulted by commissioners of NHS and public health services when there are proposals for substantial developments or variations to services, and to make comment on those proposals. (When providers are considering a substantial development or variation they need to inform commissioners so that they can comply with requirements to consult.)
- in certain circumstances, the power to refer decisions about substantial variations or developments in health services to the Secretary of State for Health.

3.3 While a 'substantial development or variation' of health services is not defined in legislation, a key feature is that there is a major change to services experienced by patients and/ or future patients. Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area. Health scrutiny committees have statutory responsibilities in relation to substantial developments and variations in health services. These are to consider the following matters in relation to any substantial development or variation that impacts on those in receipt of services:
- whether, as a statutory body, the relevant overview and scrutiny committee has been properly consulted within the consultation process;
- whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation; and
- whether the proposal for change is in the interests of the local health service.

Where there are concerns about proposals for substantial developments or variations in health services, scrutiny and the relevant health body should work together to try and resolve these locally if at all possible. Ultimately, if this is not possible and the committee concludes that consultation was not adequate or if it believes the proposals are not in the best interests of local health services then it can refer the decision to the Secretary of State for Health. This referral must be accompanied by an explanation of all steps taken locally to try and reach agreement in relation to the proposals.

3.4 The Committee is responsible for setting and managing its own work programme to fulfil this role.

3.5 In setting a programme for scrutiny activity, the Committee should aim for an outcome-focused work programme that has clear priorities and a clear link to its roles and responsibilities. The work programme needs to be flexible so that issues which arise as the year progresses can be considered appropriately.

3.6 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning. Changes and/or additions to the work programme will need to take account of the resources available to the Committee.

3.7 The current work programme for the municipal year 2020/21 is attached at Appendix 1.

4. List of attached information

4.1 Appendix 1 – Health Scrutiny Committee 2020/21 Work Programme

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 None

7. Wards affected

7.1 All

8. Contact information

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Health Scrutiny Committee 2020/21 Work Programme

Date	Items
16 July 2020	• **Covid-19 pandemic** To consider the impact of the Covid-19 pandemic on Nottingham and changes to NHS services. • **National Rehabilitation Centre – Updated Consultation Plan** To receive information on the updated plans for consultation in relation to the National Rehabilitation Centre
17 September 2020	• **NHS service changes in response to Covid-19** To review progress in restoring NHS services that changed in response to Covid-19. • **'Tomorrow's NUH'** To receive an initial briefing on the 'Tomorrow's NUH' Programme. • **Work Programme 2020/21**
15 October 2020	• **NHS Rehabilitation Centre** To consider the findings and outcomes of consultation on the National Rehabilitation Centre and how that is being used to inform decision making regarding the service. • **Managing winter pressures** To scrutinise plans for managing winter pressures across health and adult social care services • **Work Programme 2020/21**
12 November 2020	• **NHS Rehabilitation Centre** (tbc)

Date	Items
	To consider the proposals for a NHS Rehabilitation Centre and: i. whether, as a statutory body, the Committee has been properly consulted within the consultation process; ii. whether, in developing the proposals for service changes, the commissioners have taken into account the public interest through appropriate patient and public involvement and consultation; and iii. whether the proposal for change is in the interests of the local health service. • **Scrutiny of Portfolio Holder for Adult Care and Local Transport** To review plans for delivery of aspects of the Council Plan 2019-2023 that fall within the Adult Care aspects of this Portfolio. • **Flu immunisation programme** (tbc) To review provision, and uptake of the flu immunisation programme, particularly for children • **Work Programme 2020/21**
17 December 2020	• **Scrutiny of Portfolio Holder for Health, HR and Equalities** To review plans for delivery of aspects of the Council Plan 2019-2023 that fall within the Public Health aspects of this Portfolio. • **Work Programme 2020/21**
14 January 2021	• **Nottingham Safeguarding Adults Board** To hear evidence from the Safeguarding Adults Board regarding work to safeguard adults in the City; scrutinise the work of the Board, including consideration of its 2019/20 Annual Report; and identify any issues or evidence relevant to the Committee's work programme. • **Work Programme 2020/21**

Date	Items
11 February 2021	• **Work Programme 2020/21**
11 March 2021	• **Work Programme 2020/21**
15 April 2021	• **Work Programme 2021/22**

Items to be scheduled

- **'Tomorrow's NUH'** (spring 2021)
  To consider the pre-consultation business case and plans for public consultation and engagement.
- **Reconfiguration of acute stroke services** (tbc – subject to proposals from commissioners)
  To consider proposals for making changes to the configuration of acute stroke services permanent.
- **Health inequalities related to Covid-19**

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